HEALTH CARE REFORM

HEARINGS

BEFORE THE

SUBCOMMITTEE OF HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

VOLUME VI

President's Health Care Reform Proposals

OCTOBER 14, AND 15, 1993

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PRESIDENT'S HEALTH CARE REFORM

THURSDAY, OCTOBER 14, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:11 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearings follow:]

FOR IMMEDIATE RELEASE
THURSDAY, SEPTEMBER 30, 1993

PRESS RELEASE #18
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

**THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS**

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a series of hearings on issues relating to the President's health care reform proposals.

The hearings will begin on Thursday, October 7, 1993, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building. They will continue on Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. Subsequent hearings will be announced at a later date.

In announcing the hearings, Chairman Stark said: "The President's health care reform plan presents a comprehensive response to the nation's most pressing problem. The plan would commit the nation to universal health coverage and to cost containment -- goals we have been seeking for many years. The President's proposals are complex, and we want to explore this plan and the alternatives to it, thoroughly, before proceeding to mark up a bill. We, therefore, expect to hold hearings to examine various aspects of the proposals throughout the fall of 1993."

Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals.

BACKGROUND:

The first hearing, scheduled for October 7, will include testimony from representatives of affected groups, including labor unions, health care providers, and health insurers.

Testimony from Administration experts on various aspects of the President's proposals, including benefits, coverage, low-income subsidies, cost containment, governance, and Medicare proposals, will be heard by the Subcommittee at the next two hearings. The first day of Administration witnesses will be held on October 12, and the second day will be announced in a later press release.

At subsequent hearings the Subcommittee will receive testimony from Members of Congress and from representatives of other affected groups, including consumer and employer groups.

Testimony will be heard at additional hearings to focus on a series of priority health reform issues, including:

(1) Role of State governments and the Federal Government, including the role and functions of the proposed National Health Board, the Department of Health and Human Services, and other Federal agencies;

(2) Role and functions of the proposed health alliances;

(3) Health cost containment, including premium caps and alternative mechanisms;

(4) Proposed insurance reforms and their impact, risk selection, and risk adjustment;

(MORE)

(5) Impact of the plan on underserved inner-city and rural areas;

(6) Impact of the plan on low-income populations generally;

(7) Medicare savings proposals;

(8) Impact of the plan on the structure and future of the Medicare program, including the proposed Medicare drug benefit;

(9) Alternatives to the plan, including single-payer options, and other managed-competition options;

(10) Administrative simplification under the plan;

(11) Quality assurance;

(12) Fraud and abuse measures;

(13) Retiree health benefits;

(14) Long-term care benefit;

(15) Proposed standard health benefit package;

(16) Graduate medical education and academic medical centers;

(17) Impact of the plan on other affected groups and individuals.

Hearings also will be scheduled by the full Committee on Ways and Means to consider financing issues (other than Medicare savings proposals) and other tax-related matters.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Members of Congress, individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler, Diane Kirkland or Karen Ponsurick [(202) 225-1721] no later than the close of business on Friday, October 15, 1993, to be followed by a formal written request to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline and after additional hearings have been scheduled.

Individuals and organizations must specify in their requests to testify on which topic they would like to be heard. Given the limited time for the Subcommittee to hear from public witnesses, it is likely that witnesses will be restricted to one scheduled appearance before the Subcommittee. Additional comments on other aspects of the President's proposals may be submitted for the printed record of the appropriate hearing.

It is urged that persons and organizations having a common position make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Witnesses are reminded that the Subcommittee has held extensive hearings on various health reform issues earlier this year. To the extent possible, witnesses need not restate previous testimony heard by the Subcommittee.

Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

(MORE)

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, all witnesses scheduled to appear before the Subcommittee are requested to submit 300 copies of their prepared statements to the Subcommittee office, room 1114 Longworth House Office Building, at least 24 hours in advance of the scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

FOR IMMEDIATE RELEASE
WEDNESDAY, OCTOBER 6, 1993

PRESS RELEASE #19
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

**THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS**

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will continue its series of hearings on issues relating to the President's health care reform proposals with two hearings focusing on testimony from Administration witnesses.

The hearing previously announced for Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m., will begin at 10:30 a.m. All other details for this hearing remain the same. (See Subcommittee press release #18, dated September 30, 1993.)

The Subcommittee will continue its hearings on Friday, October 15, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The dates, times, and rooms for subsequent hearings will be announced at a later date.

In announcing the hearings, Chairman Stark said: "The President has put forward a comprehensive and complex plan to address the critical goals of universal coverage and cost containment. As a follow-up to full Committee hearings with the First Lady and Secretary Shalala, the Subcommittee will hold two hearings with additional Administration officials to explore the proposed health plan in detail."

Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about these hearings, see Subcommittee press release #18, dated September 30, 1993.

BACKGROUND:

On October 12, the Subcommittee will receive testimony from the Administrator of the Health Care Financing Administration, the Honorable Bruce C. Vladeck. Mr. Vladeck's testimony will focus on various aspects of the President's proposal, including the methodology for controlling the rate of growth in public and private health care spending, the employer and individual mandates, subsidies for firms with fewer than 50 employees, subsidies for low-income individuals, retiree health benefits, the Medicare prescription drug benefit, and more generally, the future of the Medicare program.

Judy Feder, Ph.D, Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, will appear before the Subcommittee on Friday, October 15th. Dr. Feder's testimony will cover issues of governance under the Administration's health care reform plan, including the role of the States, various Federal agencies, the National Health Board and the alliances. She will also focus on essential providers, insurance reforms and long-term care.

* * * * *

*** * * CHANGE IN SCHEDULE * * ***

FOR IMMEDIATE RELEASE
FRIDAY, OCTOBER 8, 1993

PRESS RELEASE #19-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES SCHEDULING CHANGES FOR HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today scheduling changes for the hearings on issues relating to the President's health care reform proposals with testimony from Administration witnesses. (See Subcommittee press release #19, dated October 6, 1993.)

The hearing previously announced for Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m., will be held on Thursday, October 14, beginning at 10:00 a.m.

On Thursday, October 14, Judy Feder, Ph.D., Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, will appear before the Subcommittee. Dr. Feder's testimony will cover issues of governance under the Administration's health care reform plan, including the role of the States, various Federal agencies, the National Health Board and the alliances. She will also focus on essential providers, insurance reforms and long-term care.

The Administrator of the Health Care Financing Administration, the Honorable Bruce C. Vladeck, originally scheduled to appear on Tuesday, October 12, 1993, instead will appear before the Subcommittee on Friday, October 15, 1993, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.

Mr. Vladeck's testimony will focus on various aspects of the President's proposal, including the methodology for controlling the rate of growth in public and private health care spending, the employer and individual mandates, subsidies for firms with fewer than 50 employees, subsidies for low-income individuals, retiree health benefits, the Medicare prescription drug benefit, and more generally, the future of the Medicare program.

For additional information about these hearings and other Subcommittee hearings, see Subcommittee press releases #18, dated September 30, 1993, and #19, dated October 6, 1993.

* * * * *

FOR IMMEDIATE RELEASE
FRIDAY, OCTOBER 15, 1993

PRESS RELEASE #20
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

**THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
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ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS**

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled two additional hearings as part of its series of hearings on issues relating to the President's health care reform proposals.

The Subcommittee will hold a hearing on Thursday, October 21, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m., with testimony from representatives of consumer groups.

On Friday, October 22, 1993, the Subcommittee will hear testimony from provider groups beginning at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.

Witnesses for these hearings will include both invited witnesses and individuals and organizations who have requested an opportunity to testify before the Subcommittee. All witnesses who will appear at these hearings, however, will be notified in advance by the staff.

The dates, times, and rooms for subsequent hearings will be announced at a later date. Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about the hearings, see Subcommittee press release #18, dated September 30, 1993.

* * * * *

FOR IMMEDIATE RELEASE
WEDNESDAY, OCTOBER 20, 1993

PRESS RELEASE #21
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

**THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS**

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled additional hearings as part of its series of hearings on issues relating to the President's health care reform proposals.

The dates, times, rooms, and topics for the additional hearings are as follows:

Tuesday, October 26	9:00 a.m.	1100 Longworth	Provider groups
Thursday, October 28	10:00 a.m.	1100 Longworth	Labor representatives
Tuesday, November 2	10:00 a.m.	1100 Longworth	Long-term care issues
Thursday, November 4	11:00 a.m.	1100 Longworth	Impact on the economy and jobs
Friday, November 5	10:00 a.m.	1100 Longworth	Role of State governments and health alliances
Tuesday, November 9	10:00 a.m.	1310A Longworth	Issues relating to risk selection and adjustment by health plans
Monday, November 15	10:00 a.m.	1310A Longworth	Health care cost containment

Witnesses for these hearings will include both invited witnesses and individuals and organizations who have requested an opportunity to testify before the Subcommittee. All witnesses who will appear at these hearings, however, will be notified in advance by the staff.

The dates, times, and rooms for subsequent hearings will be announced at a later date. Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about these hearings, see Subcommittee press release #18, dated September 30, 1993.

* * * * *

*** * * CHANGE IN ROOM AND TOPIC * * ***

FOR IMMEDIATE RELEASE
MONDAY, NOVEMBER 8, 1993

PRESS RELEASE #21-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A CHANGE IN ROOM AND TOPIC FOR THE HEARING ON
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee hearing on the President's health care reform proposals scheduled for Monday, November 15, 1993, at 10:00 a.m. in room 1310A Longworth House Office Building, will be held instead in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. (See press release #21, dated Wednesday, October 20, 1993.)

The topic of this hearing will not be health care cost containment. Testimony will be heard instead from public witnesses on issues relating to benefits under the President's health care reform proposals.

The Subcommittee hearing on health care cost containment will be rescheduled at a later date.

* * * * *

FOR IMMEDIATE RELEASE
FRIDAY, JANUARY 14, 1994

PRESS RELEASE #23
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

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COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS**

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled two additional days of hearings to receive testimony from the public, as part of its series of hearings on issues relating to the President's health care reform proposals.

The first hearing will be held on February 1, 1994, in room 1310A Longworth House Office Building. This hearing will begin at 2:30 p.m. or, if necessary, upon completion of the earlier full Committee hearing.

The second hearing will be held on Friday, February 4, 1994, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

Witnesses for these hearings will be individuals and organizations who have previously requested an opportunity to testify before the Subcommittee, in accordance with Subcommittee press release #18. All witnesses who will appear at these hearings will be notified in advance by the staff.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearings should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record, or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

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*** * * NOTICE -- CHANGE IN TIME * * ***

FOR IMMEDIATE RELEASE
MONDAY, JANUARY 24, 1994

PRESS RELEASE #23-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A TIME CHANGE FOR HEARING
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee hearing on the President's health care reform proposals previously scheduled for Tuesday, February 1, 1994, at 2:30 p.m. in room 1310A Longworth House Office Building, **will begin instead at 10:00 a.m.**

All other details for the hearing remain the same. (See Subcommittee press release #23, dated January 14, 1994.)

* * * * *

Chairman STARK. The subcommittee will continue its series of hearings on the administration's health reform plan. As a followup to full Committee hearings with the First Lady and Secretary Shalala, the subcommittee has scheduled a 2-day hearing with administration officials to explore various aspects of the proposed health plan in greater detail.

Today we will hear from the principal deputy assistant secretary for planning and evaluation of the Department of Health and Human Service, Dr. Judy Feder. The hearing will continue tomorrow with the administrator of the Health Care Financing Administration, Dr. Bruce Vladeck.

I would say for the committee that these two witnesses are probably the highest credentialed experts in the administration. I know of no one working in the current administration who has more experience in health care policy by training, academic work, or experience, than Dr. Feder. Dr. Vladeck has similarly excellent academic records and he has spent a good bit of time in the bureaucracy in the State government of New York and New Jersey.

While I would hasten to say that it's well known that the administration has not completed the detailed legislative language of its plan, it is a fact that Dr. Feder has probably been one of the principal architects of that plan. So I know that the subcommittee recognizes that there will be questions, particularly those of numbers, which really are unanswerable. The committee appreciates that, and we appreciate the administration being willing to take the time from drafting to answer many questions that I know we have.

We have a great deal of ground to cover. The members of this committee are anxious to learn more about details. We're anxious to see those hard numbers. We want to examine the underlying assumptions, however. We'll review the supporting analytic work so we can determine how various components of the plan will affect our respective constituencies. In the end, the success of the plan will depend on many of these critical details; the nuts and bolts, if you will, that hold the plan together.

I want to reemphasize, we have invited Drs. Feder and Vladeck to testify to help us understand the President's plan, and it would have been helpful had we had it. But it will be our intention to continue hearings and to ask our witnesses to return later in the course of our deliberations.

I might urge my colleagues to spend time on issues which remain outstanding. We might be better served by focusing our attention today on those decisions that have been made. Given the breadth of the President's proposal, we'll need all the time we can get to assure we understand every nuance of that. And I assure you that we will ask the administration to return each time as we schedule however many hearings are necessary to assure that we achieve the goal of understanding the plan in its entirety.

It shouldn't surprise anyone that a broad, sweeping plan raises questions and concerns. That's inevitable in a democratic process. It's my hope that these hearings and those that will follow in the coming months will give us an opportunity to complete discussion of these issues.

As part of the discussion, I invite the administration witnesses to compare the President's plan to major health reform bills al-

ready introduced in the Congress in this session. Those would include H.R. 1200, the McDermott single-payer bill; H.R. 2610, the so-called Medicare for all plan; H.R. 3222, the Cooper-Grandy managed competition approach. I understand there was a bill introduced yesterday. I don't have the number for that. Is that H.R. 3080? I'm sure the administration is familiar with that. I think it would be fair to compare differences in those bills.

I thank the committee for its indulgence. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I'm concerned about a much simpler task. That is taking what we have from the administration, the 239-page document, and getting some answers about the truth of what's there and an explanation of exactly how it works. So I have no opening statement and would like to have the time attached to my questioning period. Thank you, Mr. Chairman.

Chairman STARK. That's a new approach and the Chair will take it under consideration. [Laughter.]

Chairman STARK. Are there other opening statements that will eat into your questioning time?

[No response.]

Chairman STARK. Then I would again welcome Dr. Feder. This is your first appearance before the Subcommittee on Health in your new role with the administration. Your written statement will be made a part of the record and you may proceed in any manner you're comfortable.

STATEMENT OF JUDITH FEDER, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. FEDER. Thank you, Mr. Chairman and members of the committee. It is a pleasure to be here today to pursue with this committee our shared commitment to comprehensive health care reform. The reasons we are here are well understood by this subcommittee. No longer is lack of health security a problem for only a minority of Americans who somehow fall through the cracks. It is the majority of Americans, most of whom have health insurance, who have become afraid that it will not be there when they need it.

We are also increasingly lacking choice in today's health care system. Decisions about which health plans are available for enrollment and what benefits are offered often are not made by the families whose health care will be affected, but instead are made by their employers. This arrangement compromises not only choice, but also continuity of care on which quality rests.

Quality also is threatened as patients with ill-defined health problems bounce from specialist to specialist incurring costs for many expensive tests and procedures before they find the care they need. And practitioners lack information on what works and what constitutes quality care.

In light of these problems, it is not surprising that a large majority of Americans believe that our system needs a complete overhaul. Mr. Chairman, their demand for reform is a rational response to an irrational system. To address this demand, the President has outlined six principles on which health reform must be founded: se-

curity, savings, simplicity, quality, choice, and responsibility. Today I'm going to talk about how that reform will work.

First and most fundamental, the reformed health insurance system must be grounded in a Federal-State-private sector partnership. The President's philosophy is that the Federal Government should establish what is guaranteed to all citizens. But because health care is a local industry and a personal service, it is the States and the private sector that will develop a system to put those guarantees into effect. Let me describe how the responsibilities in this partnership will work. I'll start with the Federal guarantees.

The Federal Government will set overall standards for the new system. These standards will fix much of what is broken in the current system by providing for universal coverage for comprehensive benefits, insurance reform with open enrollment and community rating, standardized forms and administrative simplification that lighten provider's paperwork burden, consumer protections enabling consumers to evaluate plans, a quality assurance program to promote quality in all plans, the availability of multiple plans from which consumers may choose, and, finally, control of health care costs through Federal standards that will govern the changes in the private health marketplace to promote competition on the basis of quality, efficiency, and service with a backup system of premium constraints.

Now how does the Federal Government do its job? First, an independent national board will be responsible for setting many of the basic Federal standards. The purpose of this seven-member board is to have an independent body, insulated from day-to-day political pressures, address critical issues in our health care system. The board is responsible for approving each State's plan for implementing reform, for assuring that premium caps are met, for updating benefits based on changes in medical practice and technology, and for establishing performance measures for access and quality in the Nation's health plans.

With the board acting much like a board of directors, existing agencies will provide for research, legwork, and analytic support to fulfill its task. In that regard the responsibilities of the Department of Health and Human Services will include ongoing responsibilities for Medicare and public health service programs, overseeing and enforcing State compliance in the new system, promoting access and public health through the Public Health Service, and continued support for graduate medical and other professional education with a new emphasis on improving the supply of primary care providers.

Within these guidelines and supports, States and the private sector will build a system suited to each community's needs. During the past decade States have made significant strides toward health reforms that expand access, improve quality, and control costs of their citizens. Within a Federal framework States can go the rest of the way. Each State will develop for board approval a plan to provide universal enrollment, provide for a system for premium collections, implement insurance reforms, certify health plans, and provide for administration of data collection and quality management programs.

State plans will vary as States use the flexibility our proposal will encourage. States may establish alliances, purchasing pools, and provide for their boundaries, governance, and operations subject to Federal guidelines. Alternatively, States may also choose a single-payer framework in which all providers are paid directly by the State, or an all payer framework in which providers are paid common payment rates by all insurers.

For reorganizing the health care market, States will turn primarily to health alliances. Today individuals, small businesses, and not so small businesses are at a terrible disadvantage in the insurance market. The President's plan resolves the current fragmentation of demand by aggregating the purchasing power of individuals and groups into large buying pools called alliances that will be run by employer and consumer representatives. Alliances will be responsible for enrolling all individuals in their area into health plans, providing them information on health plan features, and administering subsidies.

Alliances are purchasing pools, not regulatory agencies. Their job is to facilitate a health care market that works. Any health plan that wants to operate in an area must do so through the health alliance. The alliance then makes all such plans available to its members based on competitive bids subject to a premium cap.

Now we turn to the private sector, how to buy and deliver insurance protection. First, the role of employers. All employers will contribute to the purchase of health care coverage for their employees by paying at least 80 percent of the average premium in their alliance. Based on our current estimates, the required contribution for employers in the health alliance would be capped at 7.9 percent of payroll. Additional discounts will be available to small, low-wage employers with fewer than 50 employees. Those with the lowest wages will be able to purchase insurance for 3.5 percent of payroll, roughly 15 cents an hour. The self-employed will be able to deduct 100 percent of their health expenses.

Employers of sufficient size will continue to have the option of self-insuring their employees' health benefits by forming a corporate alliance. Any private employer with over 5,000 full-time employees nationwide may elect to form a corporate alliance in which the opportunities and protections for consumers are the same as in regional alliances. These large employers may also, of course, participate in the regional health alliance with community rating and discounts phased in over time.

Now let me turn to the role of the individual. Let me be very clear. Every person will choose his or her own doctor and health plan. No employer, no government, no bureaucrat will make these decisions for us. After the employer pays its share, people will be responsible for the remainder of the premium for the health plan of their choice. For that family's share of premium Federal discounts will be available for people with incomes up to 150 percent of the Federal poverty level.

Some people such as part-time workers may also be responsible for a portion of the employer's share of premium. Federal subsidies for this share of the premium will be extended to people whose nonwage income is less than 250 percent of the Federal poverty level. Thus, the Nation's 37 million uninsured individuals and fam-

ilies, 85 percent of whom are working people and their families, will be able to afford insurance and will be asked to pay their fair share.

Along with choice and assistance must come responsibility. Under the President's plan we will all bear more responsibility for our health care decisions. Consumers will be required to enroll in a health plan and will be responsible for making informed enrollment decisions that best meet their health care needs. Consumers also will be financially responsible for the choices they make. Those who choose plans with above-average premiums may bear the additional costs themselves.

Finally, how is health insurance provided? Health plans will provide health insurance coverage much as insurance companies and HMOs provide such coverage today, except they will be operating under new rules that will turn insurance plans into health plans. The health plan's job will be to deliver high quality, affordable health care to all of its enrollees within the premium it bids.

Health plans also will have to give information to consumers through their alliances about how they deliver care. A health plan can be a fee-for-service plan like today's indemnity plans, an HMO, a preferred provider organization or other type of network, or any other arrangement that meets Federal and State requirements. There must be at least one fee-for-service plan available in each alliance.

Mr. Chairman, let me now turn to long-term care, a somewhat separate but critical component of health security for all Americans. When people are sick, they do not distinguish whether they can pay for a doctor or for someone who can help them eat or get out of bed. Throughout our health reform deliberations the administration has been unwavering in its commitment to long-term care as part of the health reform plan. The President's plan offers a package of long-term care reforms that will help mend the current system and that will address the diverse needs of people with disabilities regardless of age.

While our reforms will not address all the Nation's long-term care needs, within our resources we can make a significant and valuable start. The focal point of this reform addresses the major gap in the current system, home and community-based care. The plan would establish a new Federal-State program targeted to people with severe disabilities regardless of age or income. The Federal contribution—at a much higher match rate than in the current Medicaid program—will provide incentives for substantial expansion of these services, but will be capped to control costs and ensure predictable growth.

The plan builds on a wealth of State experience by allowing States wide flexibility to design and implement programs appropriate to their particular needs, subject to Federal standards.

In addition to this new home and community-based care program, our package of long-term care liberalizes Medicaid nursing home requirements by raising the monthly personal needs allowance and increasing the asset protection level. We will also provide a tax credit for working people with disabilities to defray some of the costs of the personal assistant services that allow them to remain employed and productive.

The President's plan also establishes Federal standards and tax preferences for private long-term care insurance and provides grants to the States to enhance their consumer education activities. This package of long-term care benefits, when fully implemented, is expected to provide assistance to about 3 million people with severe disabilities living in the community and 2 million residents of nursing homes and other institutions.

In conclusion, Mr. Chairman, we know there is considerable room for debate about the operational details of a health reform plan. But the basic principles to which we are committed are not open to compromise. All Americans must have health security, including long-term care. Everyone must make a contribution. Health care quality must be preserved and improved. Consumer choice and access to care must be enhanced. The rate of health care inflation must be slowed, and administration must be streamlined.

It is also important that States have continued and enhanced flexibility to pursue health care system improvements within basic Federal parameters for universal coverage, affordability, and quality. Each State should be able to design the system most responsive to the needs of its people.

Thank you, Mr. Chairman. That concludes my statement. I'm happy to explore your questions.

[The prepared statement follows:]

TESTIMONY OF JUDITH FEDER
PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee:

We have heard a lot in the past few weeks about the ground swell of support for health reform from the American people. As we set out to answer this call to action, we must start by recognizing that this consensus stems from the plain fact that our health insurance and health care delivery systems suffer from major flaws that threaten our health security. The basic needs of millions of hard working Americans are not being met. The quality of care is often compromised by fragmented and uncoordinated delivery of services and by a lack of useful and widely available clinical information to guide providers. And the cost of health care consumes resources we cannot afford to waste.

The causes of these problems are well understood by this Subcommittee:

* Today, insurers are free to price the sick out of the market. Pre-existing condition waiting periods in most health insurance policies force people who need care to go without coverage for months or years. Fear of losing medical coverage is keeping people in unproductive jobs or on welfare. Insurance companies compete to enroll healthy people, pouring vast resources into identifying those least likely to need medical care, not into providing care to those who need it most. There is no responsibility to provide education and preventive services, nor to provide the best medical coverage to those at risk.

* Decisions about which health plans are available for enrollment, and what benefits are offered, often are not made by the families whose health care will be affected, but by their employers. This arrangement compromises not only choice, but also continuity of care, when people are forced to change their health plan because they change jobs or because their employer switches carriers. Individuals and families who purchase insurance for themselves are at an even greater disadvantage. With no coherent system for assuring the availability and affordability of health coverage, the consumer has gotten lost.

* For the most part, health plans today are not held accountable for the quality of care their providers render, the efficiency of their customer service, nor their ability to organize hospitals, doctors, and other providers to achieve these ends within a budget. Nor could they be, under today's health system. Our nation has too many doctors who specialize in treating a single type of disease or organ system and not enough who are trained to care for the whole person. Patients with ill-defined health problems may bounce from specialist to specialist, incurring costs for many expensive tests and procedures before they find the care they need. And patients seeking care from the multiple providers -- even multiple providers within the same health plan -- can be at risk when one doctor unknowingly prescribes medication or procedures that conflict with the plan of care prescribed by another doctor.

* Our system of quality monitoring and assurance also needs significant strengthening, both to protect patients and to assist health care practitioners in their jobs. Today, data on what works and what constitutes quality care is fragmented and hard to access. For too long health care data have been collected with an eye toward what we are spending, not whether we are producing satisfactory outcomes. And for too long, information about what works and why has not been available to practitioners in a convenient, useful, and timely manner.

In light of these problems, it is not surprising that,

nationwide, 59% of Americans believe the system needs "a complete overhaul," 75% think that the cost of care in this country is much higher than it should be, 68% worry that they will have health care costs that will not be covered, and 59% are concerned about losing coverage if they change jobs. This is simply unacceptable -- we must put the consumer in the driver's seat.

Mr. Chairman, the demand for reform is a rational response to an irrational system. To address this demand the President has outlined six principles on which health reform must be founded: security, simplicity, savings, quality, choice, and responsibility. The First Lady and the Secretary of Health and Human Services, in their respective testimony before this Committee, explained how the President's plan fixes what is broken and builds on what works. In the rest of my testimony, I will describe how the President's plan fixes what is broken by putting consumers first, and builds on what works to ensure access and choice. I will focus on the roles of the Federal and State governments, and the alliances, on employer and employee responsibilities, on private health insurance reforms, and on our proposals for long term care. At the continuation of this hearing tomorrow, you will hear further testimony on the financing of health care reform, our strategy for containing health care costs, the relationship of Medicare to health care reform, and new Medicare coverage for prescription drugs.

THE FEDERAL/STATE/PRIVATE SECTOR PARTNERSHIP

First, and most fundamental, the reformed health insurance system must be grounded in a Federal/State/private sector partnership. The President's philosophy is that the Federal government should establish what is guaranteed to all citizens and what is expected of our health care system. However, because health care is a local industry and a personal service, the President also believes that the federal government is not best suited to anticipate and respond to the particular circumstances and needs of consumers and providers in each community in this country.

Because one size will not fit all, the President's plan asks each State, community and the private health care system to play a role in determining how best to provide these federal guarantees to their citizens. Individuals will also have new responsibilities. Fundamental to this Federal/State/private sector partnership is a belief that we must fix what is broken while building on what works in our current system.

FEDERAL GUARANTEES

The Basic Federal Guarantees

The Federal government, through an independent national health board and the Executive Branch departments, will set overall standards for the new system. These standards will fix much of what is broken in the current system by providing for:

Universal coverage. Through shared responsibility, employers, individuals, and governments all contribute to premiums.

Guaranteed comprehensive benefits. All health plans must offer the guaranteed national benefit package. The guaranteed benefits established initially will be comprehensive enough to cover people's health care needs. Because one size does not fit all, health plans may also offer supplemental policies.

Insurance reform. All plans must accept applicants on a first come-first served basis (unless the plan is a closed panel plan which is full). Pre-existing condition clauses,

waiting-periods, and "skimming" (selection of low risk applicants) are not permitted. Community rating is required.

Standardized forms and administrative simplification. Uniform reporting requirements and standardized forms will dramatically lighten providers' paperwork burden.

Consumer protections. Health plans must provide information about their providers, their utilization control and quality assurance procedures; these must comport with Federal rules. Throughout the system consumers will be guaranteed grievance and appeals procedures that meet Federal requirements.

Quality assurance. The Federal government will develop a quality assurance system that measures the outcomes of care and that can provide this information to consumers, and practitioners to assist them in improving the quality of care.

Control of health care costs. Federal standards will govern the reorganization of private health care markets to promote competition on the basis of quality, efficiency and service. Federal rules also will assure a greater voice in the marketplace for consumers of health care. A backup system of budgets will reinforce the efficiency-enhancing and cost-savings pressures created by the reformed markets.

Improved Choice. Putting consumers first means improving choice. Today, many people must choose from the one or two plans offered by their employer. The President's plan will dramatically increase consumer choice, by expanding the number and type of coverage options available in communities.

Role of the National Health Board

An independent national board will be responsible for setting many of the basic Federal standards. We envision a seven-member board, appointed by the President, which would be insulated from the day-to-day political pressures to which Executive Branch agencies and the Congress are subject. By establishing the board as an independent entity, and by staggering the terms of its presidential appointees, we assure that no party or administration controls the membership or agenda of the board.

Initially the board is responsible for approving each State's plan for implementing reform. It also will decide when a State is out of compliance with its plan. The board calculates premium caps and determines whether actual premiums are consistent with that cap, triggering automatic adjustments if they are not. The board also will develop appropriate risk adjustment factors, to recognize legitimate patient-driven differences in costs of care between health plans.

This board will update the guaranteed benefits over time to reflect changes in health care practices, technology, and training. The national board also will establish standards of access and quality for health plans. It will develop the core quality and performance measures for a health plan performance report along with consumer survey questions. These will be updated over time.

We envision a board that acts much like a board of directors, relying on existing agencies for research, leg-work, and analytic support. For example, while the board will be the decision-maker on the basic federal quality standards, HHS would contribute much of the research and analysis to support the board's functions.

Role of the Department of Health and Human Services (HHS)

The Department of Health and Human Services will play a key role in the development and oversight of the new system, in addition to its ongoing responsibilities for Medicare and Public Health Service Programs. For example, some of these functions will include:

Enforcing State compliance. We fully expect States to do what is required to provide health security for their citizens. Because health security will be federally guaranteed, however, we are obligated to provide for contingencies in the unlikely event that this would not occur. The Department of Health and Human Services (HHS) will have significant responsibilities relating to monitoring of State compliance. If a State fails to establish a plan or, at some later date, falls out of compliance persistently and in ways that create a serious risk that all eligible individuals will not have access to the nationally guaranteed health benefits package, the Secretary must assume the responsibility for establishing one or more health alliances, in compliance with Federal requirements. (A premium surcharge will be used to pay the costs of any Federal administration of a State's system, in the event of noncompliance.) However, States will be permitted to resume their responsibilities as soon as they are ready to do so.

Public Health Service. The Public Health Service will undertake new initiatives to reduce barriers to access and help publicly funded providers become integrated into the reformed delivery system.

Graduate Medical Education. Today, nearly 70% of physicians are specialists. HHS will play a key role in improving the supply of generalist practitioners. Based on the recommendations of expert panels, HHS will phase-in a decrease in the number of physicians entering specialty residencies and shift the focus to primary care. Everyone will contribute to the costs of funding graduate medical education through the premium structure. These funds will be pooled and allocated based on the recommendations of experts regarding the allocation of residency positions among academic health centers.

ROLE OF THE STATES

State Flexibility

As we fix what is broken, we will also build on what works at the State level. During the past decade, especially, States have made significant strides toward health reforms that expand access, improve quality, and control costs of their citizens. States also have a great deal of experience in many of the nuts-and-bolts aspects of health system oversight, such as licensure of health care providers and regulation of the health insurance industry. We would be cheating ourselves if we were to fail to take advantage of this experience at the State level.

Each State will develop an implementation plan. This plan must describe how the State will perform the following broad functions:

* Provide universal enrollment.
* Provide for a system for collection of premiums.
* Implement insurance reforms, including mandatory open enrollment, guaranteed renewability, and community rating; and financial standards for health plans.
* Certify health plans.
* Provide for administration of data collection and quality management programs.

States must designate an agency or official to coordinate these State responsibilities. Within these broad parameters, States remain free to exercise significant flexibility. States may establish alliances and provide for their boundaries, governance, and operations, subject to federal guidelines. Alternatively, States may also choose a single payer framework in which all providers are paid directly by the State, or an all-payer framework in which providers are paid common payment rates by all insurers. A State electing a single payer approach may require all employers and individuals in the State to participate in the single payer system.

The State/Federal Medicaid program will purchase health coverage in the alliance for its enrollees on cash assistance. A maintenance of effort of State Medicaid spending for current non-cash assistance enrollees will be required. Beneficiaries will no longer be restricted to the few providers who choose to accept them. They will be mainstream members of their local alliance, and will have choice of health plans available through that alliance. Medicaid will fully discount its beneficiaries' choice of plans up to the average-cost plan in an alliance.

Role of the Health Alliances

Putting consumers in charge means improving their ability to negotiate effectively with health plans. The President's plan resolves the current fragmentation of demand by aggregating the purchasing power of individuals and groups into large buying pools called alliances. Only employer and consumer representatives may serve on an alliance board of directors. Each alliance will represent all people within their borders. Alliances are <u>not</u> regulatory agencies. They will follow Federal and State rules to promote the interests of the consumers they represent.

Alliances will be responsible for enrolling all individuals in their area into health plans. In so doing, alliance will re-establish community risk pools, providing a stable actuarial base for community rating premiums. Alliances will make available to consumers information on health plan features, and will administer subsidy systems. Alliances will have important quality monitoring functions, including oversight of consumer satisfaction and disenrollment rates for health plans.

Any health plan that wants to operate in an area must do so through the health alliance; the alliance then makes all such plans available to its members. In order to obtain the best premiums for their members, alliances will solicit competitive bids from insurers and make sure that premium do not exceed the overall budget. Competitive pressures and incentives will induce plans to offer high quality service at affordable premiums in order to get and retain membership.

Grouping purchasers into alliances can eliminate much of the overhead small employers now experience with insurance coverage. Employers will be relieved of their growing health benefits administration burdens.

Putting consumers first also means making coverage choices easy to understand. The President's plan requires each health plan to offer the nationally guaranteed benefits package. With standard benefits and the comparative performance report information available from their alliances, consumers can meaningfully compare plan quality and costs, and choose the type of plan, providers and premium structure which best meet their needs.

Finally, putting consumers first means ensuring health coverage and access to care. Alliances will be required to serve every individual in their borders. They will be under the

affirmative obligation to ensure coverage and protect against discrimination. Alliance will be responsible for assuring that health plans do not selectively market to exclude low-income, high risk, or other groups. In addition, alliances have authority to use financial incentives to encourage health plans to expand into underserved areas. Alliances may also provide assistance in creating plans in underserved areas.

PRIVATE SECTOR RESPONSIBILITIES

Role of Employers

All employers will contribute to the purchase of health care coverage for their employees by paying at least 80% of the weighted-average premium for health insurance coverage in their health alliances or in their corporate alliance. Based on our current estimates, the required contribution for employers in the health alliance will be capped at 7.9% of payroll. Additional discounts will be available on a sliding-scale to small, low-wage employers with less than 50 employees. Those with the lowest wages will be able to purchase insurance for 3.5% of payroll. The self-employed will be able to deduct 100% of their health expenses.

Role of Corporate Alliances

Employers of sufficient size (as well as Taft-Hartley plans and rural electric cooperatives) will continue to have the option of self-insuring their employees' health benefits by forming a corporate alliance. Any private employer with over 5000 full time employees nationwide may elect to form a corporate alliance. These large employers may also, of course, participate in the health alliance.

A corporate alliance will serve the same functions as a health alliance, under similar requirements. (ERISA will be amended accordingly.) Corporate alliances must offer health plans that provide the nationally guaranteed comprehensive benefits. Each corporate alliance must hold an annual open enrollment, and provide comparative information about health plans. Grievance procedures and reporting requirements applicable to health alliances also apply to corporate alliances, as do administrative simplification mandates. Each corporate alliance must offer at least one fee-for-service plan and at least two other plans (with waivers for areas where such plans are not available). Corporate alliance plans must accept all eligible enrollees on a first-come first-served basis and may not terminate enrollees or limit coverage for the nationally guaranteed comprehensive benefit package. Exclusions for pre-existing conditions and waiting periods are prohibited.

Finally, plan premiums in the corporate alliances must stay within the nationally established target.

A corporate alliance makes premium payments directly to health plans, using any type of insurance rating arrangement. In addition, corporate alliances will be required to pay a surcharge to help support the infrastructure of health care, such as financing the cost of medical training and research in academic health centers, that will be otherwise supported by premiums in the health alliance. Employers that form a corporate alliance will periodically have the opportunity to switch to the health alliance. For self-insuring employers which join the health alliances, community rating and discounts will be phased in over eight years.

Together, the system of health and corporate alliances will reform markets so that health plans will have to compete for consumers on the basis of quality and efficiency. Reorganizing

markets in this way will create new incentives for providers to develop innovative approaches to management of acute and chronic conditions.

Role of the Individual

Let me emphasize: every person will choose his or her own doctor and health plan. No employer, no government, no bureaucrat will make these decisions for us.

After the employer pays its share, families and individuals will be responsible for the remainder of the premium for the health plan of their choice. For the "family" share of premium, Federal discounts will be available for people with incomes up to 150% of the Federal poverty level. Some people (such as, the self employed and the unemployed) may also be responsible for a portion of the "employer" share of premium. Federal subsidies for this share of the premium will be extended to those with nonwage income up to 250% of the Federal poverty level. Thus, the nation's 37 million uninsured individuals and families, 85% of whom are working people and their families, will be able to afford insurance and will be asked to pay their fair share.

Along with choice must come responsibility. Under the President's plan, we will all bear more responsibility for our health care decisions. Consumers will be required to enroll in a health plan, and will be responsible for making informed enrollment decisions that best meet their health care needs. Consumers also will be financially responsible for the choices they make; those who choose plans with above average premiums may bear the additional costs themselves.

Role of Health Plans

Health plans will provide health insurance coverage, much as insurance companies and HMOs provide such coverage today. A health plan can be a fee-for-service plan like today's indemnity plans, an HMO, a PPO or other type of network, or any other arrangement that meets the federal and State requirements. There must be at least one fee-for-service plan available in each alliance.

Each health plan provides to the alliance information concerning its costs, the qualifications of its providers, its utilization management and quality assurance procedures, and its consumer grievance procedures. The alliance then makes this information available to consumers.

Health plans (other than fee-for-service plans) will have flexibility in structuring their relationships with providers, and providers, themselves, will be encouraged to form new health plans. Health plans will be required to contract with Essential Community Providers during a transition period and pay them no less than rates paid to other providers in the community, or pay them based on Medicare reimbursement principles.

LONG-TERM CARE

Why We Need Reform

Throughout our health care reform deliberations, the President, the First Lady, and the Secretary have been unwavering in their commitment to include long term care as part of the health care plan. They are deeply concerned that many people of all ages with chronic disabilities lack the supportive services they need to lead independent lives at home, in their own communities:

* There are millions of American families who face the

challenge of providing long term care virtually without help. As our nation ages, we believe these informal care givers, the backbone of our nation's long term care system, need reinforcement.

* For most people the only way to obtain public assistance with long term care is first to exhaust all their financial resources in order to qualify for coverage through the welfare-based Medicaid program. Even then, access to home and community-based care may still be very limited, depending upon where a person lives.

* Talented and capable adults with disabilities are unemployed because they cannot afford the services they need to permit them to go to work.

The Administration is equally concerned that people who want to insure themselves privately against the risk of long term care are too often unable to find high quality, affordable policies on which they can depend.

What The President's Plan Offers

The President's plan offers a package of long-term care reforms that will help mend the current system and that will address the diverse needs of people with disabilities, regardless of age. The focal point of this reform is a major expansion of home and community-based care services through the establishment of a new federal/State program targeted to people with severe disabilities, regardless of age or income. The federal contribution -- at a much higher match rate than in the current Medicaid program -- will provide incentives for substantial expansion of these services, but will be capped to control costs and ensure predictable growth. Beneficiaries with incomes above 150% of the federal poverty level will be asked to share the cost of their care, according to their ability to pay.

This plan recognizes that many States, after years of struggling with the long-term care dilemma, have successfully developed innovative and creative home and community-based/personal assistance programs. This new program builds on this wealth of State experience by allowing States wide flexibility to design and implement programs appropriate to their particular needs and characteristics. At the same time, to ensure equitable access to services and consumer protection across States, the federal government will prescribe uniform eligibility criteria and require States to develop consumer-oriented services and quality assurance arrangements.

In addition to the expansion of home and community-based care, the plan liberalizes Medicaid nursing home requirements by raising the monthly personal needs allowance and increasing the asset protection level. We will also provide a tax credit for working people with disabilities to defray some of the costs of the personal assistance services that allow them to remain employed and productive.

Finally, the President's plan establishes federal standards for private long-term care insurance, with State implementation and enforcement, and provides grants to the States to enhance their consumer education activities. It also provides tax incentives for the purchase of private long-term care insurance.

This package of benefits, when fully implemented, is expected to provide immediate assistance to about three million people with severe disabilities living in the community and two million residents of nursing homes and other institutions. In addition, the steps we are taking to improve the private long-term care insurance market will raise the confidence of all Americans that high quality policies are available and will pay off when the need arises.

CONCLUSION

Mr. Chairman, there is room for debate about the details of this plan. But the basic principles are not open to compromise:

* All Americans must have health coverage.
* Everyone must make a contribution.
* Health care quality must be preserved and improved.
* Consumers' choice and access to care must be enhanced.
* The rate of inflation must be slowed.
* Administrative requirements and costs must streamlined.

It also is important that States have continued and enhanced flexibility to pursue health care system improvements. Within basic federal parameters for universal coverage, affordability, and quality, each State should be able to design the system most responsive to the needs of its people.

Chairman STARK. Thank you, Judy. On pages 4 and 5 of your testimony and on page 10, basically you say that the Federal Government is not best suited to anticipate and respond to the particular circumstances and needs of consumers and providers in each community. You also suggest that this is not a one-size-fits-all country, and I believe you indicate that you want to build on what works at the State level.

I'm going to ask you that you list for us those States where you think something is working very well in relationship to the President's goals of universal coverage, universal access, and cost containment. Do you know of any State that has a program that has achieved universal coverage, universal access, or cost containment that you can score?

Second, I want to know if you imply that Medicare has not anticipated the needs of consumers throughout this country and is not well suited to respond to particular circumstances, and whether, I presume because you are suggesting that we should turn this over to the States, that you could refute all the evidence that we have that points in the opposite direction, that the States have done an abysmal job managing the Medicaid program.

The GAO has documented that there is uneven and lax regulation of private health insurance. Oregon, for example, has just turned down its employer mandate. The Washington Post reported this morning that Maryland has not been enforcing recent reforms in regard to physicians' extra billing for tests.

So could you give us your opinion as a health care professional as to what evidence you have that the States are doing a better job with any program that we know of, as opposed to the Federal Government doing a job with programs that are operational.

Ms. FEDER. Mr. Chairman, let me go to your second question first, if I may, with respect to what I may have been implying or not implying with respect to Medicare. We share the view that the Medicare program has been extremely effective in meeting the health care needs of——

Chairman STARK. Then your testimony is incorrect on page 4 and 5 when you say that the Federal Government is not best suited to anticipate and respond; is that correct?

Ms. FEDER. No, I did not misstate, and I'm going on to the next statement which is to say that what we are contemplating in this reform is not only the restructuring of health care financing in this country, but also major and substantial changes in the delivery system. While Medicare does a good job of paying claims and paying for service, the restructuring of the delivery system has not been something that it has undertaken. It is in that regard that we believe that State and local activities are better suited to meeting the needs. So it is in that aspect——

Chairman STARK. Do you know of any delivery system that exists in this country that any Medicare beneficiary is not eligible for?

Ms. FEDER. That I think is a different question. Medicare beneficiaries are eligible for participation in organized delivery systems but——

Chairman STARK. Do you have a delivery system in your plan that isn't already in existence in this country?

Ms. FEDER. I think we are proposing to make substantial changes in the delivery system that are not operating on a large scale in this country. I think that the shaping——

Chairman STARK. I didn't say large scale. I will come back to that later in my subsequent questions. I hope you're prepared to outline to me what is different about any plan you propose that does not exist in this country in an operational manner.

Mr. Thomas.

Mr. THOMAS. Thank you very much, Mr. Chairman. It's a pleasure to have in front of us someone who's a recognized expert, not only in the general area of health care, but also on the President's plan. We've had a number of witnesses come before us and give us opinions and general statements, but they have either been unwilling or unable to respond to specific questions. All of my questions will relate to either your testimony or to the 239 document, which is the only written material I've seen available.

In your testimony, doctor, you indicate the responsibilities of the national health board on pages 7 and 8 describing a board involved in a number of decisions. Would you describe the powers of the board, such that you could fairly characterize the national health board as a minor oversight board?

Ms. FEDER. The characterization as a minor oversight board referred to minor in terms of the size of the board and its staff rather than its——

Mr. THOMAS. Excuse me, what are your degrees?

Ms. FEDER. I beg your pardon.

Mr. THOMAS. Would you please review the degrees that you hold for me?

Ms. FEDER. If you wish, I'd be happy to. I graduated from Palm Beach High School in 1964. I have a bachelor's degree in political science from Brandeis University. I have a master's degree and a Ph.D. in political science from Harvard.

Mr. THOMAS. And you're going to tell me that when someone makes the statement "minor oversight board," "minor" is a quantitative term referring to the number of people on the board?

Ms. FEDER. Mr. Thomas, I do not think that I need my degrees to answer your question, and I'm happy to answer your question about the nature of the board if you wish.

Mr. THOMAS. Not the nature of the board, the characterization of the board given its function under the Clinton health plan. It is a quote from Secretary Shalala in front of the Energy and Commerce Committee on October 5, "a minor oversight board."

Ms. FEDER. The functions of the board are to oversee many aspects of the health care system. That is a significant responsibility.

Mr. THOMAS. No, it is to approve every State's alliance; is that correct?

Ms. FEDER. It is responsible for assuring compliance, that is correct.

Mr. THOMAS. No, approving. Isn't the word "approving" used?

Ms. FEDER. Yes.

Mr. THOMAS. So obviously an attempt to extricate Secretary Shalala from a statement, which clearly is underwhelming in describing the board, leads us to argue that minor means the number of people on the board.

Ms. FEDER. Mr. Thomas, if you——

Mr. THOMAS. I'd love to have a written statement from you outlining all of the reasons why minor means the number of members on the board and not the responsibilities of the board. I'd very much like to see that on paper.

We're driven by this light. You don't have a light. We're driven by the light, so it causes us to try to move forward. On page 12 of your testimony, you say health alliances are not regulatory agencies. On page 13 you say, any health plan that wants to operate in an area must do so through the alliance. So the alliance regulates which health plans are available. In fact, it approves which health plans are available.

Doesn't that make the alliance a macrogatekeeper, not only for the plans that are available, but doesn't everyone who gets health insurance in the United States under the Clinton plan also have to go through an alliance?

Ms. FEDER. Let me clarify——

Mr. THOMAS. Yes or no.

Ms. FEDER. I'd like to clarify your——

Mr. THOMAS. Does every individual in the United States have to go through a health alliance to get coverage under your plan? That should be a simple yes or no.

Ms. FEDER. Mr. Thomas, you asked me to outline my expertise and my expertise would enable me to clarify a statement——

Mr. THOMAS. No, I asked you to cite the degrees that you held, not to outline your expertise. I wanted to know what schools you attended that took minor and made it quantitative in the number of people on the board. That was the reason for that one.

Now I've asked you another very simple question. Do health alliances operate as macrogatekeepers for, both, all the plans that are offered and all the individuals who go into those plans?

Ms. FEDER. No.

Mr. THOMAS. No.

Ms. FEDER. Would you like me to clarify?

Mr. THOMAS. Is there a way to get health insurance outside of an alliance?

Ms. FEDER. There was misinformation in your initial statement which I'd be happy to clarify for you if you would like.

Mr. THOMAS. Sure.

Ms. FEDER. When I stated that the alliance was a market facilitator not a regulator, it is not responsible for certifying the plans that are offered to consumers in a community.

Mr. THOMAS. No, your statement in your testimony is that health alliances are not regulatory agencies.

Ms. FEDER. I thought you wanted me to clarify, so let me clarify for you.

Mr. THOMAS. OK.

Ms. FEDER. Essentially, the plans are certified by the State and then the alliance offers all certified plans.

Mr. THOMAS. Does the alliance have the ability to tell a plan that it is ineligible?

Ms. FEDER. Only if it violates the contract that it makes with the plan, and only if its premiums exceed a predetermined amount.

Mr. THOMAS. Twenty percent above it.

Ms. FEDER. Yes.

Mr. THOMAS. It may exclude fee-for-service plans, even if they meet all of the requirements, if there are more than three.

Ms. FEDER. That is something that is in the document you have before you. It is something that we have heard concern about and that may or may not be in the final legislative proposal.

Mr. THOMAS. Just to finish this point, and obviously we'll talk about others. On page 60 there is, under the alliance's responsibility, a heading called "exclusion of plans." Then you go on and look at the other areas in which the alliance operates on a regulatory basis in terms of managing access to plans by individuals, and the marketing of the plans. I just find it amazing that you can make a flat statement that it's not a regulatory agency.

Then finally, and we'll have to get back to it later, you make a flat-out statement that every alliance must offer a fee-for-service plan. No qualification at all, with a period at the end of the sentence, every alliance must offer a fee-for-service plan. That's not true either, is it?

Ms. FEDER. I'm not certain that that's not true. I believe it is true. Let me respond to the general statements that you've made. We, as you know and as you continue to remind us, do not have a final piece of legislation before you. We have been working with you for several weeks to consult and get responses to our draft proposal. We have several changes under consideration.

One of the concerns that we have grappled with—both prior to proposing the draft plan and since—are the roles of the alliance relative to the roles of other parties in this system. What I am reporting to you in this statement is our intention that alliances be market facilitators. I think that you will see some enhancement of that aspect of their role in the legislative proposal and perhaps a reduction of some of the regulatory authority that may have been implied in the draft document.

Mr. THOMAS. Dr. Feder, I'm not referring to the draft document, I'm referring to your statement on page 18 where, without qualification whatsoever, there is a sentence that says there must be at least one fee-for-service plan available in each alliance. That statement simply is not true, period.

Ms. FEDER. Why do you say that's not true?

Mr. THOMAS. It isn't true.

Ms. FEDER. What are the factors that make it not true?

Mr. THOMAS. The Clinton document says that an alliance cannot allow a fee-for-service if it's over 20 percent of the weight average premium. The statement in the Clinton plan——

Ms. FEDER. That's——

Mr. THOMAS. Now let me finish. The statement in the Clinton plan that says that, even if the fee-for-service meets all of the other requirements, they can disallow them if there are more than three. There is no must-carry provision for a fee-for-service. And this statement, unqualified, leaves the impression, as you clearly did, that there is at least one fee-for-service program in every alliance and that's not true.

Ms. FEDER. I beg to differ.

Chairman STARK. We'll come back to this as we go around.

Ms. FEDER. I'd like to, Mr. Stark, because I believe I can correct this impression.

Chairman STARK. We'll keep going until everybody has had a chance. I just would like to enforce the 5-minute rule for at least the first round or two and then we'll probably wind down to a few more lengthy discussions.

Mr. THOMAS. Yes, but I didn't make an opening statement.

Chairman STARK. Mr. Levin.

Mr. LEVIN. As it so happens, I was going to talk about, Mr. Thomas, the fee-for-service provision. It was my impression from reading the document, which I did, that the aim of the administration's proposal is indeed to have at least one fee-for-service plan available in each alliance.

Mr. THOMAS. Will the gentleman yield?

Mr. LEVIN. Sure.

Mr. THOMAS. If it's the aim, I have no problem with the statement that we aim to have one fee-for-service. The flat-out statement was, there must be one. There's a world difference between there must be one and we aim to have one.

Mr. LEVIN. I don't think so, because I think the plan envisages there shall be at least one fee-for-service plan in each alliance. You also referred to a provision about disallowing a fee-for-service plan if it exceeds a certain cost. But that would imply that no fee-for-service plan within the alliance's jurisdiction would meet that criterion or other criteria. With all the fee-for-service plans out there, I don't think it's reasonable to say that no single plan would meet that specific criterion.

I think somehow we need to find a way, if I might say so, to discuss these points forcefully without necessarily being adversaries. This morning, we've already seen this morning this plan is caught between those who think it does much too little and those who think it does much too much.

So let me just ask you about this point, because I think maybe there could be an alliance where no fee-for-service plan meets the criteria, but I think that's totally theoretical. Indeed, the argument of the fee-for-service plans is that there will be so many, Mr. Thomas, why not allow every single fee-for-service plan to compete if it meets the criteria? So I want to pursue this point in a way that is not necessarily adversarial to your position or to the single-payer position.

I recently asked Mr. Gradison about this on a television program, and I must say his answer was not clear. Let's say 10 fee-for-service plans were willing to meet the minimal criteria, including community rating, for example, without exception. And let's say a State could also certify actuarial soundness, which may be a problem once you mandate or require community rating without exception. But if there were financial stability, what are the policy arguments pro and con for having a larger number of competitors on a fee-for-service basis?

Ms. FEDER. We are inclined to allow broad participation, consistent with what you're suggesting. But the reasons that in the course of the working group that we considered some limitations had to do with some evidence on administrative costs, that the multiple indemnity plans produced a higher level of administrative costs

than a smaller number. That is certainly a tradeoff with allowing flexibility in the number of plans and, as I indicated earlier, I think that we are increasingly inclined toward flexibility.

Mr. LEVIN. So the administrative cost presumably would be reflected in the premiums that would be charged. So there's a problem because some of the proponents of allowing everybody in still want to keep some aspects of rating by risk. My assumption here is they would not be allowed to do that.

Ms. FEDER. That's absolutely correct.

Mr. LEVIN. Assuming they cannot do that, then the question is whether it would not be better to allow more in rather than fewer.

Ms. FEDER. And I think that that would not be a problem, although I would want to emphasize that you're absolutely right, that the requirements for community rating are absolute.

Mr. LEVIN. Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman, and welcome, Dr. Feder. I think it is very, very important as we move through this discussion to try to be as accurate as we can. That's why the use by the Secretary of the word minor was very concerning. There can't be the impression that there is a papering over. So I want to turn to one function of this board. You say in your testimony, the board calculates premium caps and determines whether actual premiums are consistent with that cap, triggering automatic adjustments if they are not.

Now this board is going to set the global budget. It's going to allocate that budget among the States and tell each State what the cap is on its health care spending. Then it is going to approve the plans and approve the premiums that are going to be charged for the plans to see that the premiums when multiplied by the number of people don't exceed the cap. That's the way Medicare functions. Medicare is currently a function that is globally capped and that's the way we manage price setting and Medicare.

Now you say the cap and the premium, particularly the global budget and whether or not it's triggered is a backup. Now one of the really deep-seated concerns out there with your plan is that it will only be a backup if you are able to cut costs at the pace that you anticipate—which many of us believe are unrealistic but we don't have time to go into here—and if the general increase in revenues in your GDP, your economic growth estimates are realized. Because if the economy doesn't grow at the rate estimated—and I think your estimate was 5.4 percent for the very year that you think you're going to cut Medicare 4 percent.

But if those revenues don't come in and the money isn't saved then we will be pressing against that cap immediately. And I believe we will be because the global budget is already set and if, in fact, the system isn't saving the dollars you anticipated, and in fact the money isn't coming in to pay the increased Government cost then one of two things has to happen. The payroll taxes have to go up and the premiums have to be kept unrealistically low; that is, below the cost of delivering the service in order to meet the global cap.

Now my question is this. We have a board now that tells us what Medicare reimbursements ought to be. But when those ought-to-be

reimbursement rates are pressed by the global target, they have to be lowered. Now what in your plan will protect the national board from having to lower the premium rates because the global budget forces them down even though the board knows and understands that real costs are higher than that?

That is precisely what happens today in Medicaid, in Medicare, and in the VA system. The Federal global budget forces downward the reimbursement rates below real costs. And the way you have your national board structured is going to create exactly the same imperative for this national board.

Ms. FEDER. I guess I disagree, Mrs. Johnson. I think that the proposal that we have for premium caps is quite different from the Medicare payment system.

Mrs. JOHNSON. Would you please explain how?

Ms. FEDER. Yes. The Medicare payment system directly regulates the prices paid to hospitals and doctors and other providers. We are talking, number one, about a constraint on premium which is dealing with price of service and volume.

Mrs. JOHNSON. I understand that.

Ms. FEDER. That creates a very different dynamic.

Mrs. JOHNSON. No, but you see the fundamental relationship between the two figures is the same. In Medicare it's prices and you have to multiply prices times volume to see if you're within the cap. And you're going to have to multiply number of people covered times premium to see if you're going to be in the cap.

Ms. FEDER. It is different in that essentially when you regulate price and not volume, essentially as volume increases—as it often does—then you are forced to ratchet down prices to stay within a constraint. When you set a constraint—and I wanted to go to the market piece of this because it is a backup system—when you set a constraint on premium you are changing the incentives in the marketplace and you are addressing and encouraging the delivery system to address both price and volume. That is a very, very different set of——

Mrs. JOHNSON. I appreciate that. But if you set premiums unrealistically low, then the only way that that company is going to be able to stay within their own premium base is going to be to control volume primarily. What I was trying to get at earlier is that the setting of the premiums is going to be entirely dependent on the relationship between the global budget—the total amount you've said we can spend—and the degree to which your estimates as to how we can reduce costs prove true or untrue, and the degree to which other revenues that you have counted on to come into the system to pay are or are not realized.

That's the economic relationship that's going to drive the setting of the premium caps, and none of those factors have anything to do with cost or volume. So you're going to leave companies with a cap on premiums that is going to force them to constrain volume and cost in an irrational way.

Ms. FEDER. No, I think that essentially what we are talking about when we determine premiums—first of all, it's important to recognize how they in fact are set. The language of the law would determine the national level of spending, and then there are caps

on the alliances. But the actual premiums in the alliances derive from bids from health plans.

Mrs. JOHNSON. But just a minute, Dr. Feder. In your own budget, in your own testimony you say that the board must calculate——

Ms. FEDER. Yes, that certainly——

Mrs. JOHNSON [continuing]. Whether the premiums are going to exceed the cap.

Ms. FEDER. That's right, it's a backstop in each alliance. The actual premiums in the alliances are a function of the bids in that alliance. You will hear more from Bruce Vladeck tomorrow about the evidence that we believe exists that makes it possible for health plans to deliver services, when they are looking at an organized delivery system and looking at both volume and price, to come in substantially below the cap—below or at the caps that we propose.

Mrs. JOHNSON. Thank you, I'll look forward to that. My time has expired, but I would just like to add one thing in terms of my colleague from Michigan's comment on flexibility. I think you need to give some thought to the comments in your testimony on State flexibility. The fact is that the only flexibility States have in your plan is to adopt the Clinton proposal or the single-payer proposal.

I think we need to look at how States will also have the flexibility to build on our collective purchasing experience at a more modest pace and have much smaller purchasing alliances because, in fact, we have no experience with health alliances and the elaborate shift in power relationships envisioned through your health alliance and health board system. So I would like a proposal that gives States a lot more options than your proposal does give them, and that's a topic for future discussion.

Ms. FEDER. All right, and I'd be happy to pursue that further with you later.

Chairman STARK. Mr. Cardin will inquire.

Mr. CARDIN. Thank you, Mr. Chairman. I'm sorry I was a little bit late getting here. I understand I missed a comment by our Chairman in regard to an article that appeared in the Washington Post related to the Maryland effort to control cost of lab fees and physicians.

Mr. Chairman, let me just say that I wish you would have looked at the entire process that we're going through in Maryland. This is a law that took effect on July 1, 1993. If you look at the national government and laws that we passed 5 or 6 years ago, we're still waiting for regulations to be adopted according to those laws. I think the State of Maryland has moved forward rather aggressively in the implementation of its new law to try to control the cost of physician care.

A commission headed by Dr. Richardson, the CEO of Johns Hopkins, is looking at a new system to control physician cost in Maryland similar to what we've done on hospital cost, where we have been successful in dealing with not only the growth rate of hospital cost in Maryland, but to deal with some of the major problems that the Medicare system has been unable to deal with, such as providing hospital care in our inner-cities and rural areas. Yes, Medicare might be a tremendous success as far as cutting checks, but I think

it's been a failure in developing a rational system for the delivery of health care. And some States have been able to move forward to try to deal with those problems.

I just really wanted to correct the record that although it's true that we should be doing a better job on the lab fees and physicians in the State of Maryland. I think Maryland has done a tremendous job on a State initiative to deal with hospitals, and now to tackle perhaps the most difficult part of the health care system in controlling the high cost of certain physician services.

Dr. Feder, I really want to compliment you for the role that you've played in the development of this comprehensive health care plan. I really congratulate the administration for having the courage to put before the American people a bill that would comprehensively change our health care system by providing universal coverage and controlling the cost of health care.

Ms. FEDER. Thank you.

Mr. CARDIN. I just returned from a meeting of NCSL and my State legislative colleagues are asking me what can they do now as their legislatures are starting to meet and to take advantage of the flexibility that the Clinton proposal would have. They'll be needing to take action, obviously before Congress will have finally passed on the health care reform package, and obviously no one knows the specifics that will finally end up in the bill.

But could you help me in trying to give some advice to my colleagues in the State legislatures as to what they may want to consider moving forward in order to take advantage of the opportunities in the Clinton proposal?

Ms. FEDER. Absolutely, Mr. Cardin. As you well know, we have drawn heavily on what States are already doing in the design of our plan and believe that there is a tremendous congruity between what we're proposing and what many States are pursuing on their own. I think that we see that with respect to the changes, the insurance reforms, the tremendous movement in that regard. We see it with respect to the development of the purchasing pools or alliances in many States. And I think that the changes in the delivery system that we are promoting are beginning to develop and can be further encouraged.

It is our desire, as you well know, that we move as quickly as possible toward implementation of universal coverage under the new system. It is for that reason that we expect to have fast tracking, or to propose a fast tracking arrangement for States that want to come in as early as possible.

So drawing upon the broad outlines, which also include the financing system and the guarantees, a State pursuing those objectives in advance of regulations—as you note, it may take a little time with regulation—is likely to be able to proceed and move forward and operate under the new system even if not everything is in place as it would ultimately be, given time to adjust once regulations are issued. So we enthusiastically encourage States to move forward in these directions.

Mr. CARDIN. I'm glad to hear that. I had asked Mrs. Clinton when she was here as to whether the initiatives that were passed in my State were consistent with what she envisioned being permitted under the Clinton proposal and she was very encouraging

as to what Maryland had done, and particularly in its all-payer rate system.

I take it that the administration is going to be sensitive to good faith efforts made by legislatures to move toward the universal coverage, and the more open opportunities for companies to be able to purchase insurance, and the other parts of the package, and that they'll be sympathetic to look at what the States are trying to accomplish rather than looking at every specific detail as to whether it's in compliance with what some people might perceive to be a national model.

Ms. FEDER. I think it is absolutely our desire to work with States to enable them to achieve what are the fundamental guarantees in this system in the way that is best suited to their needs.

Mr. CARDIN. Thank you.

Chairman STARK. Mr. Grandy will inquire.

Mr. GRANDY. Thank you, Mr. Chairman. Dr. Feder, do you sense a certain level of frustration in the questioning of the panel or is it just me? Let me suggest why I think some of that frustration is beginning to pour out and you are, unfortunately, the recipient of that.

I think the chairman summed it up in his opening remarks. The Chairman has a bill that is written and drafted and submitted. Dr. McDermott has a bill that is written and submitted and in the legislative hopper. The GOP House Republicans have one. As you know, Mr. Cooper and I have submitted a plan. And the problem is, we have our bills out there for you to read and digest, and if so desired, draw targets around and critique, if not trash.

Unfortunately, what we have from the administration is still a system that is based kind of on principles and details that come from various different administration officials that, as you probably heard this morning, don't always agree with one another. I guess what I want to know is, let me ask you. Does the administration, in addition to the six principles in health care, want a bipartisan solution to this problem?

Ms. FEDER. Yes.

Mr. GRANDY. They do. I would assume that based on the conversation that you had with Mr. Levin and Mr. Thomas that you foresee under the plan, strong competition in the merchandising and marketing of health plans through the health alliances so—and this goes to your fifth point—consumer choice and access to care will be enhanced. In other words, regardless of the number of fee-for-service plans, there will be choice out there and that choice will be driven by competing health plans.

Ms. FEDER. In most cases, yes.

Mr. GRANDY. All right, I'm not going to criticize that. I guess what I'm asking for is, can we expect the same amount of competition in the making of health care policy as we can under your plan with the merchandising and marketing of health care policy? In other words, are we going to be in the loop or is bipartisanship going to be trying to get Republicans to sign off on the administration plan. Will there be a meeting of the minds, whether it is Mr. Stark's plan, our plan, or the MediSave plan introduced by Senator Gramm just yesterday?

Ms. FEDER. Mr. Grandy, this gives me an opportunity then to talk about what I see is quite similar in the plan that you have put forward and what the administration is proposing.

Mr. GRANDY. I appreciate that, but I want to go to one other thing, Dr. Feder, because this is what bothers me, the disparity between promise and practice. Are you familiar with a piece that was written in U.S. News & World Report this week that basically identifies you as—this is the good part—the architect of the President's health care plan who was ordered to call reporters on a list of newspapers in Louisiana, Texas, and Tennessee. Her mission, to explain why the Clinton proposal was superior to the legislation to be introduced by congressional moderates; a measure considered more in tune with sentiment on Capitol Hill.

The targeting of these States was deliberate, the key House sponsor of the rival legislation Jim Cooper is from Tennessee. One of his chief allies, Charles Stenholm, represents a Texas district. Louisiana's John Breaux plans to sponsor the Senate version. The White House concentrated its fire on Tennessee because it evidently feels that Cooper, who will challenge a Democratic incumbent in a senatorial primary next year, is especially susceptible to intimidation.

The premise here is that in addition to architecture, demolition is one your skills. There is a covert attempt to trash proposals that are written and drafted and before the public, before we, even see your plan or, have a chance to merge the two.

Now I'm going to give you a chance to refute this. Were you out there making these calls, laying the seeds of doubt on the Cooper-Grandy plan before we've even seen your plan, or is this just trash, yellow journalism at its lowest. You can hereby be exonerated in public on C–SPAN forever and for even people in Europe to know, Dr. Feder?

Ms. FEDER. May I say, without acceding to your adjectives there, that there are significant inaccuracies in the U.S. News report. We are actively communicating with the press on a regular basis and I did have telephone calls within those States in the last week. Let me tell you what it was that we discussed.

It was a group of reporters on a conference call. They began by asking me about the Tennessee waiver, an issue I was happy to defer to——

Mr. GRANDY. This is the TennCare matter, not the Cooper-Grandy bill.

Ms. FEDER. That's correct. They began by asking me about the Tennessee Medicaid waiver, the TennCare program, again, which I was happy to defer to my colleague who will be here tomorrow, the HCFA administrator, Bruce Vladeck. They asked me extensive questions about the adequacy of the financing for the Clinton plan which I hope I addressed successfully. They then asked me questions about the Cooper-Grandy bill to which I responded by talking about the areas that we had in the common and the principles that caused some concern.

Neither my intent nor my outcome, I suspect, resembled trashing or demolition in any way, and I'd like to go a little further in that regard.

Mr. GRANDY. Can I just ask you, before you go further, is there an attempt by the administration, covert or overt or anywhere in between, to prevent members of either party from sponsoring this bill in the House?

Ms. FEDER. I'm not aware of that.

Mr. GRANDY. All right, continue.

Ms. FEDER. What I would like to focus on is what I believe represents an effort that we can all engage in, and I would argue that we have been engaged in over the several months, to look for areas of common ground. I think that there are several of those in the Cooper-Grandy bill. I think that the commitment that you put forward to changes in the delivery system is quite similar. I think we have that very much in common, and I think that we have built on what you have done in the past and would like to continue working with you in that regard.

Mr. GRANDY. Let me just say, because my time has expired, I have been criticized—you'll be interested to hear this. I've been criticized in the media back home for being too friendly to the Clinton plan. My feeling has always been that there is more that unites us thematically than divides us in details. But I am very concerned that there is an operation that may—and it may be above your level, Dr. Feder. I'm not trying to put you on the hook here.

But there is a concern that those of us who have introduced this bill, or those who are on other proposals are going to be criticized first and consulted later. I think that way leads to the kind of confrontation that divided us so deeply on the budget. And I don't think the President wants that solution on health care and I hope you don't either.

Ms. FEDER. I would say that the evidence that that is not our intent is the extensive consultation process in which the administration has engaged over the last several months with meetings with members of both sides of the aisle on a regular basis examining basic issues, fundamental issues in health care reform. I would say that that attests to our commitment to consult as we continue to debate.

I would also say that when it comes to examining your bill that has been introduced relative to ours, that is about to be introduced, that there is plenty of material on the table to enable us to engage on the broadest level, which is perhaps most critical: that is, the capacity of either or a combined proposal to achieve the goals of security, savings, quality, simplicity and so on, and I'm happy to discuss those issues with you.

Mr. GRANDY. I will, in my next round of questioning. But I hope we can agree that there is no way a bill can pass without a bipartisan coalition that is committed to holding the center of this debate. Thank you.

Chairman STARK. Mr. Kleczka will inquire.

Mr. KLECZKA. Mr. Chairman, I'm going to pass at this point and try to get up to speed.

Chairman STARK. Without objection. Mr. McCrery will inquire.

Mr. MCCRERY. Thank you, Mr. Chairman. Dr. Feder, there is some frustration in Congress because when we got the 239-page draft, we could read draft, but we also thought that it pretty well embodied what the plan was to be, particularly with regard to the

specifics that were contained in the draft. I understand from you this morning that the draft was in fact a draft and anything in it is subject to change before the final version.

Ms. FEDER. Mr. McCrery, as Mr. Grandy just indicated, we intend to be—or as we discussed, we are engaged and have been engaged in a consultation process. I think that you would be disappointed if we did not respond to some of the questions and concerns we have heard from you and that we have actively sought.

Mr. MCCRERY. Certainly we would be disappointed if we weren't consulted on legislative activity. But we've been expecting this since May and we're now in October and now we're told we may wait till November before we get a legislative vehicle. I'm also hopeful that once the legislative vehicle is introduced that it is not the final product either; that we can still consult, change, and agree on some changes.

Ms. FEDER. Our goal is to get health reform.

Mr. MCCRERY. But you can understand why some of us are frustrated a little bit.

Ms. FEDER. Let me share with you, nobody wants more than I do to have this bill out there.

Mr. MCCRERY. I'm sure. But in fact, the draft document that we have had access to does have some particulars in it and we have been relying on those——

Ms. FEDER. As you should.

Mr. MCCRERY. And that accounts for the statements of Mr. Thomas and others with respect to the fee-for-service question because there are some particulars in the plan with respect to that. Something that's not been brought out yet, and I want to make sure you are aware of what's in the draft, if you haven't seen it. On page 62 of the draft, it says that an alliance can get a waiver from the national health board of the requirement to offer a fee-for-service plan. So, in fact, an alliance does not have to offer a fee-for-service plan if it gets a waiver from the national health board. Maybe that will be changed when the final legislative vehicle comes to us, but that is in the draft.

Ms. FEDER. I also wanted to, if I may, Mr. McCrery, I wanted to clarify in terms of the questions that Mr. Thomas raised earlier about——

Mr. MCCRERY. I'll let you answer his questions on his time.

Ms. FEDER. OK.

Mr. MCCRERY. I'm sure you will want to address that. I just wanted to make you aware of that being in the draft.

Also in the draft is something relative to price controls. I think you stated earlier that you do not intend to set prices in the Clinton health plan. But in fact—and I misstated the page number—page 62 is the reference to setting fees. On page 62 it says, a provider may not charge or collect from a patient a fee in excess of the fee schedule adopted by an alliance. That's with respect to fee-for-service plans. So in fact you do set fees in the Clinton health plan with respect to fee-for-service plans. Again, maybe that will be changed in the legislative vehicle that we finally get, but it is in the draft.

Ms. FEDER. May I respond to those?

Mr. MCCRERY. Sure.

Ms. FEDER. First, with respect to the waiver that you alluded to on fee-for-service. That waiver exists only if there is no provider interest in a fee-for-service plan. So that, I think, is an important clarification, as is essentially what I would like to clarify, which is that the availability of fee-for-service is an overriding commitment independent of the 20 percent restriction that Mr. Thomas was referring to.

On the second point that you raised that has to do, if I understood you correctly, with respect to balance billing. It does not affect what a provider charges or the terms that a provider negotiates with a health plan. It only says that those charges are the maximum that a provider may charge and that they cannot charge additional amounts to consumers.

Mr. MCCRERY. So it seems clear to me, it says that a fee schedule will be adopted by the alliance.

Ms. FEDER. It's a negotiated fee schedule in the fee-for-service system. That is a negotiated arrangement.

Mr. MCCRERY. I'd like to get in later maybe some thoughts about why there would be no interest in a particular alliance in a fee-for-service arrangement. I think that's a good point, and I think that certainly we're going to have some alliances in which there will be not be any interest in providing fee-for-service arrangements.

Ms. FEDER. I think this is a question of our dealing with all contingencies. That is the simple answer on that.

Mr. MCCRERY. It's a good point that you brought up and it deserves more exploration.

Chairman STARK. I'm going to suggest that the gentleman's time has expired and we'll come around again as quickly as we can.

Mr. MCCRERY. Thank you, Mr. Chairman.

Chairman STARK. Mr. Kleczka?

Mr. KLECZKA. Thank you, Mr. Chairman. Dr. Feder, I'd like to return to the discussion of the national health board. I had to testify before another committee and I heard it was broached before, but let me ask some additional questions.

My reading of the draft indicates that there will be seven full-time members of the board and its duties and responsibilities are numerous. Attached to the health care board will be at least six or seven commissions doing various things. Now my view of this health care board is that it's going to be a monster of an agency, one which I bet will be larger than HHS eventually.

Could you give an idea to the Committee on the structure of the board? How many employees you think they might have? What their budget might be? Will they have rulemaking authority? What's the salary level of the seven health board members appointed by the President? Could you just give some more background on that?

Ms. FEDER. Yes. I think what is most helpful also is to understand the concept behind the board. As I indicated in my opening remarks, the objective is to have an independent agency that is removed from the day-to-day political pressures, that is not under the control of a political party, and is able to apply expertise and represent the concerns of consumers during the major decisions in the health care field. I think that as we looked at a number of bills, that their idea of a board—including Mr. Grandy's bill I believe—

that their concept of a board is something that is shared. That's the reasoning behind it.

To achieve that objective requires a decisionmaking function, not an extensive staff or a full department or a replication of HHS, to achieve the responsibilities that the board is given.

Mr. KLECZKA. Could you be more specific? I only have 5 minutes. How many employees are envisioned to be attached to the board? Will they have rulemaking authority, things of that nature? What do you envision the salary of these seven commissioners, or whatever you want to call them, to be?

Ms. FEDER. I will have to examine those specifics. I don't have those for you. The size of the board we are thinking of in terms of roughly 100 employees. That is the number that we have talked about because of an expected reliance on the contracting function.

Mr. KLECZKA. Contracting with existing agencies?

Ms. FEDER. Exactly, correct.

Mr. KLECZKA. I'll tell you, in my short time around here that doesn't work. Agencies don't talk to each other around here. If this national health care board calls up Donna Shalala and says, I need some legwork done on this study or whatever, Donna is going to have her hands full because those people are doing other things in the department. So that ain't going to work. They're going to have to hire their own actuaries, their own CPAs. What's the salary level of these seven big shots?

Ms. FEDER. I'll ask the staff.

Mr. KLECZKA. What's the salary level envisioned for these folks? I'm wondering whether or not I should apply for it.

Ms. FEDER. May I ask your degrees?

Mr. THOMAS. Do you know anything about health care?

Mr. KLECZKA. No, but nor will they. [Laughter.]

Mr. KLECZKA. Bill and I wanted to apply in tandem. So none of those specifics have been worked out yet; is that what you're saying?

Ms. FEDER. I don't have those for you, that's correct.

Mr. KLECZKA. And in 2 weeks we're going to get them?

Ms. FEDER. Probably so.

Mr. KLECZKA. That's the line in the committee here, it's 2 weeks.

Ms. FEDER. Again, I don't want to play that game because essentially I think what's important here is, our objective is to focus on the intent of the board. The specifics of its operations we certainly can work on with you before or after the legislation is introduced. The goal is, as I indicated, to have a separate, and independent agency dealing with what are controversial matters. And my information now is that the board members would be paid at comparable salaries to SEC or other agencies reflecting the role and the stature that we wish to give them.

Mr. KLECZKA. FCC or FEC?

Ms. FEDER. SEC. And if there are significant differences there that would affect your application we could certainly look into that. [Laughter.]

Mr. KLECZKA. I'll wait for round two. Thank you.

Chairman STARK. This begins round two. Dr. Feder, I would like to go back to both a statement and a question I made when the distinguished gentleman from Maryland was not present. My ques-

tion was directed to the witness, and we'll perhaps come back to it, as to whether States or the Federal Government were best suited to guaranty the benefits.

I questioned that assumption that the States would fulfill the guarantees based on evidence, and I then cited that States, in general, have done an abysmal job managing the Medicaid program, and that the GAO has documented uneven and lax record of States in regulating private health insurance. Blue Crosses have gone broke, and we've been stolen blind in California. But Oregon, for example, just had to reverse its stated stand on enforcing employer mandates. Then I said that in the Washington Post that Maryland, even Maryland is having a difficult time enforcing recent reforms.

Now I think it's also fair to say that the Chair has, over a period I'm sure of at least 6, if not 8 years, repeatedly stated that the only two States that have accomplished anything in the area of cost containment are Maryland and New York. And they've done it principally only in the field of hospital costs and to some extent hospital capital expenditures. Maryland has done a significantly better job than New York. But there are no other States that have even approached that.

I believe that Maryland has spent probably 10 years attempting to get an agreement to bring other providers, principally physicians, under some kind of cost containment, and as have other States, they're having a difficult job. This is not true of Medicare. For better or for worse, it does have cost controls in all 50 States and it does cover all the providers.

There's no question that tremendous improvements are needed. But the evidence is that we have on the one hand a plan, albeit imperfect, and the only evidence is that we have but one State that has taken the lead in finding the way to do it, for which I have frequently commended Maryland and will continue to do so. I wish it Godspeed in bringing these greedy physicians under control who are outrageously extra billing our beneficiaries for services which seem to be nonexistent.

Having said that, I would like to go back and let Judy finish on the issue of what State does have something that works that you choose to pattern your universal access and coverage or cost controls after?

Ms. FEDER. You also asked in your earlier remarks whether there was any evidence that any State had done this.

Chairman STARK. That's right.

Ms. FEDER. I think with the exception, and even it is incomplete, of Hawaii, there isn't a State that has done this. I think that we are in complete agreement that without a Federal framework and without Federal guarantees, to rely on States to be able to pursue this alone is not possible. When we look at the Medicaid experience I would say, sadly, that the difficulties in administering that program are shared by State and Federal governments alike; it really is the States that have been grappling with many of the problems in that area.

Chairman STARK. Excuse me just a second, maybe I'm missing something.

Ms. FEDER. That's the point.

Chairman STARK. This committee has precious little jurisdiction over Medicaid, but my guess is that we do nothing in the Medicaid program except give money to the States. There's only 120 employees at HCFA out of 3,500 who work on Medicaid, and my understanding is all they do is cut checks. Now is there anything else we do?

Ms. FEDER. There have been, and I don't need to belabor it, but I think that there have been over the years different responsibilities that have been at the Federal level that have then disappeared from the Federal level. There were opportunities to exercise responsibility——

Chairman STARK. Let me put it this way. Would you say that in Medicaid we have any more control over the States than we do over the control of insurance, for instance?

Ms. FEDER. What I think is, my point here is to say that that is a program that is limited to the vulnerable populations of this society, and all levels of government I would argue have been lacking in adequate commitment to——

Chairman STARK. A point well made and a point well taken, I might add, by the Chair. Thank you.

Mr. Thomas, do you want to continue your line?

Mr. THOMAS. Thank you. No, I don't want to continue my line. I want to get a complete understanding of this plan. My problem is that in reading the materials I have difficulties in understanding your plan. I would like a very simple answer to a simple question.

The question I start with is this. Does the national health board approve State plans? Does it approve the plan for establishing an alliance? Page 42 of the Clinton plan lists the national health board's responsibilities. It says, the National Health Security Act creates an independent national health board responsible for setting national standards and overseeing the establishment. On the same page, under oversight it says, "the board establishes requirements for State plans."

It continues on page 47 under the national administration, the national health board reviews plans submitted by the States. Nowhere in this document can I find the phrase, "the national health board approves the State plans."

So that's my simple question. Does the national health board have the power to approve a State plan? It can oversee it; it can establish it. Can it approve it?

Ms. FEDER. Yes.

Mr. THOMAS. Yes. Are there any conditions for the alliances, totally preconditioned in the alliance itself, that require the national health board to approve it, in terms of geography or scope?

Ms. FEDER. In the Federal law there are standards for the size of an alliance with respect to its being adequate to——

Mr. THOMAS. You mean in the plan, not in the law.

Ms. FEDER. No, in the statute we would expect there to be some standards for the alliance.

Mr. THOMAS. In the bill that you're going to introduce.

Ms. FEDER. That's what I mean.

Mr. THOMAS. Not in the law, not in the statute. Those are on the books, and we're going to do everything to make sure that that doesn't happen in the way that you're offering it.

Ms. FEDER. Obviously we have different objectives in that regard.

Mr. THOMAS. That's correct. Objectives are different. You had already assumed that you'd had your——

Ms. FEDER. I misspoke and I meant in our legislative language.

Mr. THOMAS. Thank you for that. Now let's go forward.

There is one preclearance that I can find in your document for an alliance on its size, scope, makeup of enrollees, income, or anything else. Right?

Ms. FEDER. I beg your pardon, there is not one, did you say?

Mr. THOMAS. No, there is one that I can find. For example, the national health board could easily turn down a plan even if the State decided that they wanted one alliance for the State. There's nothing in this plan that says that a State that builds a single alliance for the State will automatically be approved.

Ms. FEDER. The conditions for approval have to do with achieving the overall national guarantees; that is approval of a State plan. Is there a particular——

Mr. THOMAS. I understand that. But there's nothing in here that I read saying that if the State creates an alliance encompassing the entire State boundary—since it's clear, given the rules, an alliance cannot go outside the State boundary—there is no automatic preapproval of an alliance that is the exact size of the State. The only preclearance approval is if it is a consolidated statistical metropolitan area. That is assumed to be as qualified alliance. That's the only one that the national health board cannot overrule; is that correct?

Ms. FEDER. Well, the board essentially—I believe a clarification is in order. The board is approving a State plan which has several components and——

Mr. THOMAS. I understand that. I prefaced it by saying, focused on the geography, the size, the makeup, the racial mix, the ethnic mix, and the financial mix.

Ms. FEDER. It would seem to me then that it is not a problem, and if there is some need for clarification in that regard I would——

Mr. THOMAS. No, my point is that the only one that is precleared is a consolidated statistical metropolitan area. All the others are subject to the approval of the national health board. A consolidated statistical metropolitan area is not a statistical metropolitan area. It is something far different and far larger. For example, in the State of California it isn't even the county of Los Angeles. It is eight counties in Southern California that construct that.

Now California is very sensitive, given the current economic climate, of how many jobs are going to other States. One of the things that other States are doing is creating attractive tax packages to steal employers, and therefore, employees away from California.

The concern that I have is that the preclearance of a consolidated statistical metropolitan area, or any other clearance which cannot weigh ethnic or racial or financial concerns, is going to create in many instances a clear disincentive for an employer to locate themselves in that city that's within an alliance. Because, given all of the other requirements for a health plan you are going to have to absorb, on a universal basis, the cost of all of the health expenses of that area including the inner-city cost of a crack baby of between

$50,000 to $100,000 a person. It seems to me that there is an enormous incentive in some of these operations for discouraging employment.

Has there been any consideration about the ability to offer tax incentives, or the denial of tax incentives which are currently going on now, to modify an alliance or the health plan so that it isn't, on the basis of its structure, a clear disincentive? Because what happens under your plan is that even if the State wants to make adjustments for this or any other reason, it must get the approval of the national health board.

And if you're at loggerheads between the State and the national health board, the national health board has absolute power under your plan to come into a State and run a program. It can also assess the people who live in that State not only the cost of the health care program itself but all of the administrative cost. In all of your discussions with all the people in building the plan, did anybody talk about the problem of the current structure of tax incentives to attract employment and the disincentive that a consolidated statistical metropolitan area will have for employment attraction?

Ms. FEDER. The boundaries of the alliance, the concern has to do with a number of the issues that you raise. They are critical issues in terms of building a community pool. The thinking that we went through in terms of the design of the requirements was to develop as broad a risk-sharing base as possible. That's the reason for looking at the metropolitan statistical area.

Mr. THOMAS. My time is up, but let me say that I would suggest that in focusing on the health aspect of it, you may have created enormous economic, employment, and political problems akin to redistricting regarding when and how these lines are drawn.

Ms. FEDER. I think that there are issues about the structure of the pool and if there are particular specific technical problems that we need to address further we're happy to do that.

Thank you.

Chairman STARK. Mr. Levin will inquire. And if I may intrude for a moment, at the completion of his inquiry, it will be the Chair's intention to recess until approximately noon for the benefit of the witness and others. The witness has to be somewhere at two. Can you get there in a half an hour?

Ms. FEDER. Yes. No problem.

Chairman STARK. We will attempt to go straight through, giving the witness breaks as we break for voting, if that's agreeable. Mr. Levin, why don't you inquire? At the conclusion of your inquiry, we'll recess for approximately 15 minutes.

Mr. LEVIN. Thanks. By the way, I think some of the efforts to scale down the powers of the board may be in response to the efforts of some to make it into some monster bureaucracy. Also, let me just say, in terms of discussion of the States, I think it's true that they haven't done a good job in containing costs.

Many of them haven't done a good job at reducing crime or the number of people driving under the influence of alcohol either, but we still try to provide some Federal support fore these functions without taking them over. This kind of a diversified approach in health is not unique.

By the way, do you know whether—Mr. Grandy isn't here, I was going to ask him—whether his plan's costs are being estimated in the same comprehensive way as the administration's plan? Do you know that?

Ms. FEDER. It is hard for me to imagine that there is any plan that is being costed out to the degree that——

Chairman STARK. If the gentleman would yield. I believe that the previous plan submitted did get a CBO estimate, and that there's precious little difference between the previous plan and this one.

Ms. FEDER. Did it have official——

Chairman STARK. It had CBO.

Ms. FEDER. I meant CBO official, as opposed to——

Chairman STARK. The previous plan did and the current plan is drafted with the proviso that it would be adjusted to CBO numbers. And the plans are very similar.

Mr. LEVIN. But as I understand it, each and every major component of the administration's proposal is being costed out, is it not?

Ms. FEDER. That's absolutely correct.

Mr. LEVIN. Is that equally true of Mr. Cooper and Mr. Grandy's plan?

Ms. FEDER. Well, the effort in which—and I was being somewhat flip—but the effort in which we've been engaged has been extensive and exhausting, if not exhaustive. Essentially, we are relying on internal expertise; in different places within the administration, several agencies are involved. We have also relied upon outside analysts experienced in estimating the costs of plans.

Perhaps one of the reasons for frustration and confusion in terms of numbers that come out, sometimes reflects both the continued refinement of the estimates and our effort to reconcile estimates from different sources. So I would say that I believe that I speak the truth when I say that it is an effort that may be more extensive than other proposals have been subject to.

Nevertheless, it will be CBO scoring that is of greatest concern to you. We believe that, in many respects, the kinds of expertise that we have brought to bear in modeling are something that CBO will be interested in, because it has not done some of the things, or explored some of the issues in terms of changes in behavior that we have attempted to capture. So we would be happy to be of assistance to CBO in that effort.

Mr. LEVIN. One last, quick question. I think we probably have what, 7 minutes? One last, quick question. On page 10, you talk about decreasing, over time, the number of physicians entering specialty residencies and shifting them into primary care. This approach is based on experts recommendations.

Now we're all struggling to find a balance between competition and regulation. Let me ask you quickly, why have you opted for some kind of regulation here, in terms of the mix of physicians?

Ms. FEDER. If we are going to support a change in the delivery system to place a greater emphasis on primary care and on better management of care, the demand for primary care practitioners is enormous. There is a tremendous concern that the incentives in the training of residents right now, handled as they are by institutions which rely on these residents to provide services, create in and of

themselves very powerful pressure to continue an emphasis on specialist training.

So it is our view that we need to move the system more heavily in the direction of primary care training with further interventions.

Mr. LEVIN [presiding]. Thank you. The subcommittee will stand in recess until noon or shortly thereafter.

[Recess.]

Chairman STARK [presiding]. We'll resume. The witness and our guests can make themselves comfortable. The Chair will take this opportunity of golden silence to get a couple of questions in.

Is the long-term care benefit a Medicare benefit?

Ms. FEDER. No.

Chairman STARK. Because the Chair has some concern about this issue—I can't pronounce it, but I think it's called duplicitousness. That's an issue that has been hinted at by Mr. Magaziner, who has blithely said that savings are going to go to fund a drug benefit and long-term care program. I received a book from the White House. I think you've been made familiar. This is a book exhorting us to go home and sell this plan. It asks will my Medicare coverage be affected? That's a sample question.

It says no, you'll receive Medicare and you'll continue to receive all the benefits. In addition, the Medicare program will be strengthened by adding prescription drug coverage and expanded options for home and community-based long-term care.

That's somewhat misleading, is it not?

Ms. FEDER. I think it's unclear, Mr. Stark.

Chairman STARK. OK, I just want to make the case that if we promise too much, or try and convince people—and I tried this, as a matter of fact, in a caucus of our members and many of the members felt indeed that the long-term care was going to be a Medicare benefit, or an entitlement.

Let's get to that. The long-term care is going to be a block grant, in effect, to States and, I believe that you say that the Federal contribution will provide incentives for expansion, but the contribution will be capped to control costs. That's correct, is it not?

Ms. FEDER. That's correct, yes.

Chairman STARK. Now, capping to control costs isn't a lot different from capping premiums on acute care, is it? You're limiting the amount of money that will go into it. But there's a major difference.

If under the acute care you are willing to say we're going to cap the money going in, but you are providing a minimum level of benefits, why wouldn't you do the same thing for long-term care and cap the money you're going to pay the States but not let the States wiggle out by watering down benefits? Would that not be at least consistent?

Ms. FEDER. I think it's certainly true, we could have gone another way. Would you like me to elaborate?

Chairman STARK. I understand the reason capping so as not to let the entitlement go up on insurance and on long-term care. I also understand the reason for having a minimum benefit package, so as to not let the alliance or the accountable health plan wiggle out.

I know my own State, for instance, chisels on us when we increase the benefits under SSI. Governor Jerry Brown and Governor

Pete Wilson have both not increased the benefits to the beneficiaries. They've spent the money on something else.

And there would be nothing in this block grant to prevent them from doing that, unless we had a minimum level of benefits below which they couldn't go. I just wonder why it wouldn't be a good idea to do that. Let the States then figure out how to do that within the level.

Ms. FEDER. Let's talk about that a little. First of all, one of the issues in terms of the structure of the program is to have it operate as a claims-based system. So that when we call it a block grant, I think that we have to be careful to recognize that there has to be spending on services to get funds. If there are concerns about that, we need to work very hard on making that clear and operational.

In terms of a specified minimum benefit, we looked at that in the course of the working group, essentially of guaranteeing some level of benefit as an individual entitlement. The difficulty that we face in that regard is that there is tremendous variation, as you well know, among different population groups who need long-term care, the elderly versus, for example, the developmentally disabled.

There are differences in people's circumstances, affecting the need for services and need for formal support on top of their family assistance. And if you establish a minimum entitlement, you essentially have fewer resources to distribute based on——

Chairman STARK. I know. But what you're doing is telling the senior citizens that you're going to cut their funds out of Medicare, which is already an entitlement, and then blithely suggest that you're giving them prescription drugs, and long-term care. I'm saying if you told the senior we're going to cut your entitlement here, to give you an entitlement of long-term care, you and I aren't going down the same street together.

I don't think it's proper, in the first place, to cut their entitlement by using Medicare savings, and then provide the States with a block grant that no one can really assure the seniors that they'll end up getting some specified level in an entitlement fashion to long-term care.

Ms. FEDER. Your point about entitlement is valid. The long-term care program is not an individual entitlement. It is an entitlement to States. I also think your point is well taken, with respect to clarification, as to who is eligible for that benefit. It is for all people who satisfy the disability requirement, independent of any Medicare eligibility.

But I think that I would like to say a few words, if I may, about the value of this benefit to seniors. I think that essentially what we are putting forward in the home and community-based care program is a dramatic expansion of resources that would be available in all States—it is not today—that would enable us to go from serving roughly 300,000 persons with severe disabilities getting some service today to 3 million when fully implemented. Although people of all ages would benefit, as I would argue they should from this program, seniors are disproportionately likely to need long-term care services, and that is a fundamental gap in their protection which we believe this begins to address, though we recognize it is a step on our long-term care problems, not a full solution.

Chairman STARK. The light wasn't running, but I think we've consumed 5 minutes in that area. I'll call on Mr. Thomas and let you go ahead.

Mr. THOMAS. Thank you. Thank you for hanging on. It's very frustrating when we have to run over and vote. I tried to listen to as much as I could of my friend from Michigan's discussion with you on the finances.

I know that you folks have gone to great pains to emphasize the certification of your finances. When the First Lady was here, she said not only were the numbers scrubbed by CBO, but by outside accounting firms and there can be no argument with the numbers. Now whether or not we achieve those numbers, that's a different question. But the numbers are pretty good.

In the plan, the 239 page plan, there is for want of a better term, an appendix. It's not numbered in the back, but there are a number of charts and other detailed information which came with the 239-page document. You're probably familiar with this chart on the finances that's in the back?

Ms. FEDER. Yes.

Mr. THOMAS. Since these numbers have been scrubbed, not only by CBO but by outside accounting firms, can you explain to me the budget mechanism that is contained in the Clinton health care plan that makes sure that the Medicare savings of $124 billion go only for the long-term care, the Medicare drug benefit, public health and administration? Will any of the dollars achieved by reducing the Medicare package to the senior citizens go down here to deficit reduction?

What's the budgetary mechanism that guarantees that all of these arrows are, in fact, the way the money goes, including the division of the sin taxes in early years and later years to different funds?

Ms. FEDER. First, I think it's important, lest it come up another time, I would like to clarify what you're saying about scrubbing the numbers. We have been in contact with CBO, but CBO cannot essentially assess our numbers until it has a bill. So I don't want to leave any misimpression in that regard.

Mr. THOMAS. What I'm saying is in essence the numbers will be precleared, because once they're in the package, CBO will already have approved them. And so, they're going to be precleared. Otherwise, you wouldn't put the number in, would you?

Ms. FEDER. I think that what CBO does is respond to our legislative proposal, and whether that——

Mr. THOMAS. So CBO has looked at no numbers? None of the staff of CBO has examined any of your numbers, and they won't until you hand them the finished document?

Ms. FEDER. No, Mr. Thomas, that is not what I said. What I said was I did not want to give the impression that CBO had given a stamp of approval to our numbers, because it has lacked the information to do that. What we have done with CBO, as with a number of other experts, is be regularly in contact with respect to our methodology and our estimating procedures, so that we are in sync in how we are estimating.

Mr. THOMAS. Then with that understanding, what is there in the Clinton plan that guarantees that the arrows directing the money

from the various funding sources, in fact, are guaranteed to go where the arrows show they go?

Ms. FEDER. What I would say is that the specifics in terms of the funding will be provided to you with the legislative language and that this chart, as are the other charts, was meant to be illustrative when we were describing the bill.

Mr. THOMAS. Illustrative means not necessarily accurate, but generally representative of the way things are. Would you accept that?

Ms. FEDER. I will temporarily, until I get into trouble on it.

Mr. THOMAS. Is it possible that the Medicare reductions could, in fact, go to deficit reduction, violating the arrow direction on the chart?

Ms. FEDER. The slowdown in Medicare growth and its dedication to particular cost activities to play a particular financing role is something that we are examining and we will clarify that. It is our intent that it go to expanded services, as our zealousness that Mr. Stark referred to indicated.

Mr. THOMAS. But I know you're familiar with the system, and I know that intent oftentimes gets deterred and unless you lock in some kind of a funding mechanism following these arrows—this is, in fact, not even illustrative. It is misrepresentative, because it makes it look like certain funds are going certain places, when all of us know the funds are aggregated both on the savings side and on the spending side. You cannot, in fact, produce a chart that shows where the money comes from and where it's going.

Ms. FEDER. I think I would take issue with that but I think it is absolutely appropriate that we be held accountable for demonstrating the mechanisms, if we intend that they be——

Mr. THOMAS. If you take issue with it, at the beginning it was the very question I asked. You had 5 minutes to answer how the Clinton administration could justify money coming from one area and being spent in another without violating the arrows put on this chart by you folks.

Chairman STARK. Mr. Cardin will inquire.

Mr. CARDIN. Thank you, Mr. Chairman.

I just want to followup a little bit on Mr. Grandy's comments about the consultation process and the need for bipartisan cooperation. I couldn't agree more. I think just about every member of this panel has either filed or sponsored legislation on health care reform. I think that those bills further the debate, particularly as we compare the achievements toward the goals that the President enumerated, how well the various plans reach those particular objectives. So I think it's very useful.

I do, though, want to compliment the administration for the most open process, the most consultation I think in the history of Congress between an administration and both the Republicans and Democrats on crafting legislation. In fact, let me just compare that to the process that was used a year ago—this might be a real trivia test—as to what Democrats President Bush met with before he filed his bill on health care reform, if anyone can remember that legislation.

So I really want to compliment the administration for its outreach to seek the advice of all Members of Congress and the public

at large, in putting forward this bill; and your willingness to review the contents of the legislation during this hearing process in efforts to improve upon some of the points that have been brought out, as long as we achieve the objectives that the President has spelled out.

I also want to comment a little bit on what my Chairman said, and I appreciate the kind comments he made about the State of Maryland. But under our current system, it's virtually impossible for a State to be able to achieve the objectives of universal coverage. With the current ERISA laws, it's impossible because of the prohibitions contained in that law from certain State actions, and the limitations on State financing make it extremely difficult for a State to get universal coverage, not only the limitations of its ability to finance, but also the competition among various States and the funding mechanisms it would use make that almost an impossible task.

So I think that the President's proposal again, establishing a national structure for a system, but giving maximum flexibility to the States, is the best way to move forward in achieving universal coverage.

I want to ask a question that troubles me about one of the aspects of the President's plan. Although I do think we have to have some form of an overall budget discipline, and although we hope that the cost savings will achieve the targets that the President has established, we need some way of making sure we achieve those savings.

I am concerned how premium caps work among the States. We've talked about this before. We start from what the States are currently spending, which appears to reward those States that have been less aggressive in controlling costs and penalizing those States that have been more aggressive in controlling costs.

In the initial draft document, there was some effort to defer this to a commission to see how we would go into a transitional phase to try to alleviate those inequities. I'm wondering whether you could perhaps give me a higher comfort level that those States that have been more aggressive in keeping costs down will not be penalized in the way that the allocations are made, vis-a-vis the premium caps?

Chairman STARK. If the gentleman would yield, my comfort level in a State that has been abysmal in controlling costs and has a shameless record of having two or three times the cost of the good State of Maryland is abysmal. On the other hand, I have to be parochial. I'd hate to see that money taken away and given to Maryland.

Can you assure me that if Maryland gets some extra money for doing a good job, that California won't be penalized for doing a bad job?

Mr. CARDIN. No, I want you to assure me that California will be penalized for doing a bad job. I want some of California's money.

Ms. FEDER. Is it time to take a break? I think we have here before us the dilemma of achieving perfection and equity as we move through change in a system. As we discussed this before, Mr. Cardin and Mr. Stark, I think there's a recognition that we need

to start the system where it is with a recognition that there are differentials that we would expect to see changes in over time.

This may not be a comfort, Mr. Cardin, but I think you have emphasized and clearly recognized that Maryland has a system in place that enables it to fairly readily continue to keep its costs under control, and that as it uses that system, as well as changes in the delivery system, its capacity to comply, to achieve premiums readily and easily may put Maryland ahead of some other States where there is more change needed in that regard.

I think that our concern is that to move more aggressively at the outset would imply that we knew exactly what the level of spending ought to be, or the rate of increase in various States. And as our system is changing, we need the flexibility to adapt to that. So I would expect that we will have a commitment to moving toward a lesser variation over time, and the specifics on that we will continue to work on.

Chairman STARK. Before I recognize Mr. Grandy, I would like at some point later for you to apply that statement. Start the system where it is relative to HIPCs and alliances. I think that's a convenient term. We are not starting the system where it is, in terms of the delivery, as you so correctly corrected the Chair.

I wonder if you're not being a little selective in responding why we should start the system where it is in terms of penalizing Maryland, when we may not start the system where it is in terms of penalizing insurance companies?

Ms. FEDER. Well, I don't think that we have penalized Maryland, so I think that that's important. I think that's a bit of an overstatement of what's happened, but I think that in terms of changing the insurance industry, if we are going to achieve our objectives in all States, we need to move aggressively to reform that industry. And I would argue that if we have——

Chairman STARK. How about being aggressive in the way we pay physicians and hospitals then?

Ms. FEDER. Well, I think that essentially we are, with respect to allowing plans to be aggressive in that regard and to work with providers to achieve objectives.

Chairman STARK. But not States?

Ms. FEDER. A State that chooses to do that can absolutely do that.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman. Dr. Feder, I think I heard you say to Mr. Thomas that at this point CBO has not officially scored the Clinton plan. Scrubbing the numbers in consultation notwithstanding, there is no official score on the Clinton plan. That is correct, isn't it?

Ms. FEDER. That's certainly true.

Mr. GRANDY. I appreciate your saying that, because that kind of ties in I think with the cease-fire where we agreed to not trash each other's plans, at least in the short run. I feel constrained because evidently Mr. Levin asked you some questions about the Cooper-Grandy scoring. CBO has scored our bill. It is $125 billion over 5 years and the specific details are available.

I might say parenthetically that obviously—and you know this, too, because you have to live under the same guidelines that we

do—you cannot really get an effective score for savings you might get from the lack of defensive medicine through malpractice reform and administrative savings. To a degree, the Cooper-Grandy bill tries to overfund the bill because we are compensating for scores that we feel are there, but CBO will not acknowledge.

Let me ask you a couple of particulars, and I realize there are no details, but there are some things that are of concern that have been coming up through briefings. I would like to ask particularly about the retiree health program. It is my understanding that if this were to be enacted into law, the cost share would basically involve the Government picking up 80 percent of the retiree health benefit program. Is that correct?

Ms. FEDER. The subsidy pool would pay for 80 percent of the premium.

Mr. GRANDY. So that is a public plan. That is the Government's responsibility. Who picks up the other 20 percent?

Ms. FEDER. That depends upon the individual's prior relationship with the employer. What we have in the document that you have is that an employer, who had a contractual obligation to pay the 80 percent, would then pick up the 20 percent. Otherwise, individuals then are obligated to pay that themselves, with the subsidy support that I described.

Mr. GRANDY. That's worth talking about, because as I understand it could conceivably happen, that as employers move their corporate responsibility to the public sector, individuals who were under an employee-based plan and were paying 20 percent—let's say that you get your 80/20 mix—would no longer have to pay anything for retiree health because employers would not pick up 20 percent, admittedly a good deal if you're paying 80 percent.

But I go back to the point that you made in your conclusion of your prepared remarks, where you said everyone must make a contribution, and my concern is we are not exacting that promise from early retirees but from their employers if we say the split now is 80/20. Uncle Sam is picking up 80 percent and previous employers pick up 20 percent. Is that not a correct representation of the retiree plan?

Ms. FEDER. The statement that everyone makes a contribution would still hold for those individuals because of the cost-sharing that is required and associated with different plans.

Mr. GRANDY. But if there is now a public plan which is dominated by the Federal Government in early retirement, and you know Uncle Sam is going to pick up 80 percent of the benefit, are you saying that that 20 percent is split 80/20 between previous employer and present retiree?

Ms. FEDER. When I said that the contribution is still there, I'm talking about when people purchase services. When they use services, there is still a contribution. What you have characterized is accurate.

Mr. GRANDY. Thank you. I realize we've talked about long-term care and this is a long-term answer. Do you have numbers, even in a preliminary stage, as to what the expected cost of the long-term care proposal is in the President's plan?

Ms. FEDER. Yes, we do. The numbers are in the tables we were looking at earlier. Those were the preliminary estimates.

Mr. GRANDY. Do you happen to know what they are, off the top?

Ms. FEDER. The expenditures for the full long-term care package, as reported in that table, were $80 billion over 5 years.

Mr. GRANDY. Now I want to stress, because there has been some question as to what your team of actuaries actually scored and certified and what they did not. They did not actually come up with that number; isn't that correct? That $80 billion does not have kind of the actuarial seal of approval that some of the other components of your plan have; is that correct?

Ms. FEDER. We have used different sources. This is not an insurance program, and so to essentially look to actuaries to assess premiums would not be appropriate here. We have relied on both internal administration expertise and on external modelers in this area to estimate the long-term care benefit, as we have on every other aspect of our program.

Mr. GRANDY. I understand that, but what you're basically saying is that these are assumptions and estimates, as you characterize them, that have not supposedly been as perused by the actuaries as some of the other benefits.

Ms. FEDER. No, I can't accept that. I guess what I have to say is that they have been reviewed by the internal actuaries who do that for the administration and by appropriate external experts, as have the others been reviewed by appropriate external experts.

Mr. GRANDY. So you stand by the $80 billion cost over the life of the plan?

Ms. FEDER. I stand by it as an estimate that may be modified somewhat as we are going through our internal refinement process, but I am comfortable with the number that is before you.

Mr. GRANDY. Thank you, Mr. Chairman.

Chairman STARK. Thank you. On page 9 of your testimony you say that Health and Human Services assumes the responsibility for providing care and that it would put a premium surcharge on health insurance in that State, in order to provide it.

Then on page 47 of document number 239, it says that the Secretary of the Treasury will impose a payroll tax sufficient to allow the United States to provide coverage to everyone in that State. But you say, further on page 47, that in the interim—whatever that interim may be—the Secretary of Health and Human Services will withhold Federal health appropriations if the State is not in compliance.

Those are two different cabinet posts imposing various penalties on various States. What is the present means by which you intend to force compliance on the States?

Ms. FEDER. The testimony is accurate, except that—and I'm just reviewing it to see—we did not mean to rule out what I believe is in the earlier document, with respect to withholding of some Federal funds as an interim measure.

Chairman STARK. Which funds did you have in mind?

Ms. FEDER. Funds under the control of the Department of Health and Human Services, so that could include Public Health Service funds, medical education funds——

Chairman STARK. Medicaid, Disabled, Title XX?

Ms. FEDER. The focus, as I believe our listing suggests, is on funds related to graduate medical education and on the specific programs, not with respect to entitlement funds.

Chairman STARK. Would you tell me, for instance, that the good State of Vermont, that the University of Vermont, which I believe is the only medical school that we withheld the graduate medical education funds to the State of Vermont, that that would yield sufficient dollars to pay for insurance for the good 500,000, or 600,000 burghers of the——

Ms. FEDER. I think that the—no, I would not say that. I think that the broad issue here is how we move toward——

Chairman STARK. What I'm getting to is under that broad issue. It seems to me after you took all of the graduate medical education money, the only money left in the Health and Human Services funds for the good State would impact most severely on the sickest, most elderly, disabled, poor and disadvantaged population. So the odds are in some States, is it not correct, we would be withholding money from the most fragile population?

Ms. FEDER. And that is why I emphasize the broader concept, the broader scope of the funding withholding there. But the issue is—I think your broader issue is how do we achieve compliance. And that is regarded as an inducement to compliance, rather than a funding of—in the case of noncompliance.

Chairman STARK. It's two parts. One, there's a penalty. But second, there's a Federal responsibility to do it if the States don't. So in compliance, I'd like to know how you're going to do it and who's going to do it.

Ms. FEDER. First, I think that I just wanted to be clear that the fund withholding component was still there. However, as emphasized in my testimony, if in fact compliance does not occur, then it is necessary—in the unlikely event that that does not occur—it is necessary that we specify a mechanism for guaranteeing the citizens of a State that they have the coverage that they can expect under this program.

That's why I laid out, in my testimony, that it is the role then of the Secretary to assume responsibility for establishing the alliances in the State.

Chairman STARK. The Secretary would create an alliance——

Ms. FEDER. That's the purpose of the premium surcharge. Did you want me to address the change from the earlier document to the current?

Chairman STARK. Yes, premium surcharge on whom?

Ms. FEDER. It is a surcharge on the premiums in the State. So essentially, the intent here is to establish the same kind of system in the State that would have been established had the State complied with the expectations in the first place. So it is a premium-based system and the surcharge is intended to cover the Federal administrative costs.

Chairman STARK. And would the Secretary have to stay within the national budget?

Ms. FEDER. The general requirements would have to be met.

Chairman STARK. So that a State that felt it was unable to stay within the budget could say OK to us, you guys do it and we have the same responsibility to stay within the budget. Is that——

Ms. FEDER. Yes, and if you're asking with respect to the particulars of the surcharge, I'm not certain of that piece and its application to the budget, but the obligation is to achieve the objective. I think that as we look at what we expect States to do, that I would make a couple of observations.

One is that when we are talking, when we have responses to our proposal and reactions from various parties, that is not necessarily reflective of what would be in a real situation; that we do believe that there are substantial benefits to all States from going forward with the legislation. As Mr. Cardin indicated, there is substantial assistance in the overall program in achieving the financing objectives by having all States participating, as well as the momentum and technical assistance and other parameters of this bill to achieving valuable ends for employers and individuals in a State.

Chairman STARK. Thank you. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Back to our arrows. On this chart it's titled how reform is financed. And on the left side it says sources of funds, and on the right side it says uses of funds. Now I need you to explain to me the use of the arrows, between the sources of funds and the uses of funds.

Had there been no arrows, I wouldn't bother to present the chart because I would have agreed completely that this is where the money is coming from and this is where the money is going to be spent. Somebody in your shop felt it necessary to draw an arrow from one source of funds to show that it was going for a use of the funds, and that none of the Medicare money winds up on deficit reduction.

Was there a rationale for the use of the arrows, and are you aware of it?

Ms. FEDER. The rationale for the use of the arrows is to indicate the way in which we believe that new expenditures are offset by other sources of revenues.

Mr. THOMAS. Is there any device, in the Clinton health care plan, in any of the current budgetary procedures in the House of Representatives, or in any legislation that you and the administration plan to introduce, to your knowledge, that would have these arrows in fact have any effect whatsoever?

Ms. FEDER. Mr. Thomas, that's where I did ask to reserve the judgment or the answer to that question until we put the legislative proposal before you.

Mr. THOMAS. And I anxiously look for that.

Back to the health alliances. Under the structure the national health board cannot question a State if it maintains a health alliance isomorphic to a consolidated statistical metropolitan area. That is the only area I can find in the plan that the national health board cannot make a judgment about the makeup of the health alliance. On all others they can.

For sake of discussion, let's take a State which has a consolidated statistical metropolitan area as one alliance and the rest of the State as another. Here are some of my concerns about that kind of a structure.

I looked at the mechanism of establishing the alliances in the first place and the clearing of the alliances through the national

health board and the power that the national health board has in approving or dissenting on every alliance except the consolidated one. My experience is basically political science and I've spent a lot of time on election reform and I've spent a lot of time on redistricting. I've gone through several in California.

I've looked at the courts in terms of the way they have looked at redistricting and what they posited as a model and what resulted in terms of the model. I am very concerned about the politics of creating alliances because if you have a consolidated statistical metropolitan area, which by definition surrounds an urban area, it is almost always such that large metropolitan cities have inner-city poor, oftentimes ethnic and racial minorities, many of them immigrants, whether illegal or not, in their boundaries. And that the medical costs are enormous per person based upon past history of failing to take care of themselves and perhaps not making the best judgments in terms of choices even under a new system.

Those costs are going to be absorbed by everybody within that alliance. The way in which the alliance is defined, and if the rest of the State doesn't include those folks, there is an enormous hidden tax on everybody else inside the alliance constructed on a consolidated statistical metropolitan area.

Was there any discussion about—and I don't mean anything pejorative by the terms, but I think they're representative of the arguments that are made—white flight out of the cities into the other alliance because of that enormous hidden cost? The choices of employers are not moving into an area where we have Federal programs where we're trying to attract employers to come into the inner-city? They used to be called enterprise zones.

What are they called now? You guys are doing them. Empowerment zones. Ours were enterprise zones, yours are empowerment zones. I like enterprise zones.

These are programs where we're trying to attract employers to come into the inner cities, and here we've got a structure which looks like they're going to take a look at their increased medical costs of their folks absorbing the costs for all the inner-city folks. They could move outside that alliance to a suburban or a rural alliance and not have to carry the weight of all the inner-city poor and all their complications.

Was that discussed in terms of the political ramifications of the way in which alliances are constructed and the one alliance that's given absolute OK, no matter what?

Ms. FEDER. What I said before holds with respect to discussion of this overall issue—that our objective in establishing the metropolitan area distinction was to avoid isolation of at-risk populations. So I think we have given considerable consideration to that issue.

I would also say that when we look at this that we need to look at the current system, and in the current system essentially it is the providers who are in inner cities who are serving the at-risk populations. It is the employers in the current system who finance care for those who live in these areas, and who bear these costs. And in this regard, we will be making improvements in the new system by essentially sharing more fairly the distribution of costs

in a more rational system. And I think we will see improvements in that regard, rather than a deterioration.

Mr. THOMAS. What I'm saying is that I think you ought to at least engage in a discussion about the primacy of a consolidated statistical metropolitan area and that primacy delivering what you just said you wanted.

It may make total sense, as in reapportionment sometimes things don't make sense until you realize dividing that inner city right down the middle and combining it with the other portions of the State spreads the costs of the inner city equally across the State. Then you don't have any of those other undesirable side effects that I talked about.

But by making it an absolute in which the national health board can't even consider, I think you've elevated it to a position that may, in fact, bring about one of the things you were most concerned to avoid.

Ms. FEDER. I hear your concerns and I think that what is most important to us is creating appropriate pools and we can continue to discuss it.

Chairman STARK. I'd like to follow on that. Mr. Cardin has graciously allowed me to intercede here to follow on that, because this is a question that I'd like to establish.

On page 50 of document number 239 it is stated that States may not establish boundaries for health alliances that concentrate racial or ethnic minority groups, socioeconomic groups or Medicaid beneficiaries. And alliances may not subdivide a primary metropolitan statistical area. You go further, an alliance that covers a consolidated MSA within a State is presumed to be in compliance.

I have heard, and I'd like you to tell me, Judy, that it is the current intention of the task force or the drafters of this to allow dividing MSAs into more than one alliance.

Ms. FEDER. That is not my understanding.

Chairman STARK. Mr. Magaziner was quoted as having made that deal with the Governors earlier this week to allow them to carve up MSAs as they chose. Now, are you going to tell me that absolutely a MSA may not be subdivided into more than one alliance?

Ms. FEDER. It is not my understanding that we have made any change in that provision.

Chairman STARK. The concern both Mr. Thomas and I raise is the gerrymandering skills of Phil Burton. I can tell you that his spirit lives on in California, and you would soon find alliances that were adjusted to suit a lot of causes other than that.

Would health plans be permitted to serve restricted areas within MSAs?

Ms. FEDER. It is up to the State as to whether the areas that plans serve are defined, or whether they are defined in the alliance. However, there are antidiscrimination provisions, or will be antidiscrimination provisions, to prevent plans from the aggressive gerrymandering that seems to be your concern.

Chairman STARK. I'm not sure that's exactly my question. If a health plan chooses to serve only a certain geographical area—let's take the District of Columbia, which is a MSA—and it's a State by the terms of your plan, could a health plan say that it will serve

only residents in Wards 1 through 6 and not Wards 7 and 8, under any circumstance?

Ms. FEDER. That is essentially left to the District of Columbia or the State government to determine.

Chairman STARK. Personally, I find that a serious flaw. I might state for the record that we have testimony from insurance companies who suggest that that's exactly what they would do in the District of Columbia. They are allowed to do it in Maryland, and therefore they will serve Maryland, but the District laws prohibit that and so they won't serve the District. So Prudential and others would choose not to serve the area, and that it seems to me is something we'll have to discuss later.

Mr. THOMAS. Would the gentleman yield briefly?

Chairman STARK. Yes.

Mr. THOMAS. One of the difficulties is the Census Department's definition and the way in which the definitions work themselves out into population areas of a metropolitan statistical area. As a primary metropolitan statistical area and a consolidated metropolitan statistical area, Washington, D.C., is lumped with Maryland, Virginia, and West Virginia as a primary metropolitan statistical area. It's lumped with Baltimore, Virginia and West Virginia as a consolidated metropolitan statistical area. It may stand alone as a metropolitan statistical area.

But the only one that's protected under the plan is that consolidated plan. So anything that D.C. does is going to have to be approved, unless you're elevating D.C. to a State.

Ms. FEDER. I think the latter is correct.

Mr. THOMAS. And even if you elevate D.C. to a State, I find nothing in the information that I see now, and I'm looking forward to the language in the bill, that guarantees that a State can have an alliance isomorphic to its own boundary.

Chairman STARK. I'd like to recognize the future Governor of the District of Columbia, once we cede it to the State of Maryland and see how he feels about this plan.

Mr. CARDIN. I was just wondering whether this plan provides for two U.S. Senators and one Member of the House for the District of Columbia?

Ms. FEDER. I perhaps overspoke when I answered your question.

Mr. CARDIN. I think this discussion with Mr. Thomas and Mr. Stark is very helpful, but I think there is one point that needs to be emphasized as we look at the fairness of regional areas. I think we tend to think too much of the current system of health care with its inequities.

But one of the principal objectives of the President's package is to eliminate uncompensated care, and uncompensated care is one of the driving factors for the discrimination of locating a facility in an area of high cost, because a lot of that high cost is represented by uncompensated care.

The second problem that I would hope would be addressed by the Clinton package is that we want to eliminate the discriminatory medical practices with poor people, by having poor people gain access to the same health care system that privately insured people do.

In that light, let me ask a question if I might as to how the Medicaid system is folded into the health care system of privately insured individuals. I have seen that work in my own community. We have the Prudential plan in Baltimore where Medicaid people and privately insured people get their health care in the same setting. It's happened in the Columbia Medical Plan.

And in both cases we've seem that the cost of providing the health care to the medically indigent has actually dropped and the quality of care is improved. So you can achieve cost savings with higher quality care.

I guess one of the objectives that I'm not sure we've achieved in the Clinton proposal is the elimination of cost shifting, which is another problem that occurs in some of the issues raised by my two colleagues. So perhaps, Dr. Feder, you could go over for me how the Medicaid system gets folded into the system, as far as the individual being able to access a health plan?

How does the financing follow? Will there be a disincentive for a health plan to attract a medical assistance person because the reimbursements are lower, the premium level is lower than what it would be for a privately insured person and we have cost shifting to a plan? What type of assurances can we have that there won't be that type of disincentive?

Ms. FEDER. First, let me clarify the extent to which there remains what is really appropriately characterized as a Medicaid financial obligation or a Medicaid eligible person. There are many people for whom Medicaid is currently responsible, because they spend down or are medically needy, or because they are in categories like pregnant women and children of higher than poverty levels, higher than cash assistance levels.

Those populations will be part and parcel of how the overall system is financed. If they are working, they're covered through employment. If not working, they are covered through the other mechanisms. They no longer have any relation to a Medicaid responsibility.

The population that is on cash assistance, Aid to Families with Dependent Children or Supplemental Security Income will now have their premiums paid through Medicaid funds, Federal and State.

Mr. CARDIN. But will those premiums be the same as the premium paid for a privately insured individual?

Ms. FEDER. The first question you asked, if I could go back to it, was what plans would they have access to? And those premiums would be paid to all plans that were below the average premiums, so that beneficiaries have access to the full range of plans up to the average premium in an area.

So in terms of your objective of integrating the Medicaid population into the broader system, that is achieved both by the first clarification I made which is the population now on Medicaid that is now part of our system, as well as by this folding in.

Now let me go to the payments. The payments for the population on cash assistance, the Medicaid premiums if you will, will be based on current per capita spending for those populations. But we're dedicating 95 percent of current levels because we expect

some of the savings that you have described. But they are tied to current per capital spending rates.

Those premiums are paid into the alliance and then averaged with the privately bid premium by an insurance plan. And that averaging is not based on the plan's population; it has nothing to do with their mix beneficiaries. The averaging is based on the alliancewide distribution of the population including Medicaid beneficiaries and private purchasers.

So that all plans, regardless of the people they serve, are having an averaged payment on this basis.

Mr. CARDIN. Does that mean that a plan then is not adversely impacted by a large number of medical assistance individuals?

Ms. FEDER. It absolutely does.

Mr. CARDIN. I think that's a major improvement. We still have some cost shifting and you're stopping the erosion of more cost shifting and perhaps improving it somewhat.

Ms. FEDER. Let me give you, if you wish, the logic behind that. Essentially what we believe is—and I think there is evidence to support it—that although there are arguments that Medicaid has often underpaid or has underpaid in some circumstances, what the cost shift has done is to put that into the private sector payments. What we are doing by averaging them, you are correct, is essentially building that in and making it no worse.

Mr. CARDIN. It's a practical solution.

Ms. FEDER. I appreciate that.

Mr. CARDIN. Thank you.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Back to the alliances and the mechanism of the national health board in approving a State's plan. My understanding is from this proposal that if a State plans to be a single-payer State that that's acceptable under the plan.

On page 49 you have a series of criteria—and I'm looking forward to the legislation to see the amplification and the standards and the structures for approving or disapproving—of the content of the State plan. As I understand the first one, the administration of subsidies for low-income individuals, the certification of the health plans that are going to be approved, the financial regulations of the health plans, administration of data collection and the rest.

The last bullet says the establishment and governance of health alliances. Did the task force ever consider that it would be conceptually possible to meet every one of the requirements of service, cost and convenience, package, all of the requirements except it isn't a single-payer system and it doesn't create mandatory health alliances?

I think it's very easy to conceive of a State being the insurer of last resort, providing other options, being able to certify that everyone is covered and otherwise, but your plan doesn't allow that structure to be approved.

Mr. THOMAS. You require a State to either be a single-payer—and escape some charges if they go that way which appears to me to be an incentive for going to single-payer—or create a structure which you folks have sat around in a room and devised. Why isn't there an option for saying that if you're equivalent, if you've met

all the requirements that we ask of the delivery of health care and the coverage, which you've told me if your basic concern, why can't a State be allowed to do that?

Ms. FEDER. Mr. Thomas, first of all, I'm not certain what incentives you saw toward single payer so we could discuss that separately. But essentially, we are committed in this reform to achieving universal coverage in a system that essentially transforms our insurance system. As we worked very hard in many rooms to determine, we looked at an array of options as to what would achieve that objective. The single-payer option is one that many advocate and we believe States should have that option.

In terms of a State that chooses to continue to rely on an insurance market, we looked at an array of measures to reform the insurance market to achieve administrative simplification, a broader pooling, and fair mechanisms for determining rates and enrolling people. In doing that we drew very heavily on experience in several States. Those States are at various stages of development, but we drew extensively on it. It is that experience that led us to the design that we put forward.

Mr. THOMAS. My concern is that you, in fact, went back and emphasized that you drew heavily on various States that are in the process of modifying. The health care world of 1993, the role that States are playing, and the changes that have been made is significantly different than the health care world of 1990 from what I've seen in terms of actions that have been taken by the States.

In fact, if the Federal Government would pass some enabling legislation dealing with antitrust—and I compliment the administrative moves. We need to go beyond that to allow creativity among professionals—some malpractice reform, some insurance reforms, some enabling legislation in the area of administrative simplification of forms and the rest. Then I think we can have the States be even more creative.

If these standards are desirable, I don't understand how you can then reach a conclusion in America 1993, given the dynamics of the changes that are going on in health care delivery, payment, and all the rest, that you are now going to lock in a form which you just admitted was transitionary and evolving. You ought to provide an opportunity for creativity if a State can meet all of the substantive requirements you say are important to delivering the package.

You've told me that you have decided to elevate yourselves to a position of denying a State the opportunity to put in a program because of the overriding importance of changing the insurance market. I'd much rather talk with you about statutory changes in the insurance market, imposing it upon that industry instead of limiting the choices of a State in meeting the health care needs of its citizens.

If you will look at page 54 and the requirements that a State does not have to meet or gets waived if it goes to a single payer, there are dollar costs involved with those. I think a State would at least have to look at the cost and weigh the two choices, and I believe it creates an opportunity to be an incentive for a State to move toward a particular plan. Why couldn't those same things be waived by a State if they could prove other factors?

My concern is that you folks have elevated yourselves to a position in, as you admitted, a rapidly changing world of denying certain options. Some of which, I think, would provide an opportunity for perhaps an even better model within the next decade. If your plan passes, you're going to cut off creativity, not only at the State level for organization within the various health care industries, but also the ability of professionals in organizing plans and themselves in bringing about cost savings.

Yours is a good model. I don't know that it necessarily should be the only model. I'm looking for a bit more choice. If I meet your substantive requirements, you ought to be able to waive it for people who come up with new ideas. I see no growth potential for new ideas in your plan.

Ms. FEDER. Mr. Thomas, I would take issue with that and I would say that——

Mr. THOMAS. You've taken issue with everything I've said.

Ms. FEDER. As you have with what I have said. I think that it is our objective here, as I have stated many times, to achieve a broader pooling in the insurance market to guarantee people security, and to avoid cherry-picking which has become endemic.

Mr. THOMAS. As am I, but I don't want to dictate one system.

Ms. FEDER. What I would say is that within——

Chairman STARK. We'll come back to this. We'll try something else for a few minutes which is just as much fun.

It's my understanding that in picking up the retiree income unfunded liability each company's assessment would be equal to half the gain it realizes over the first 3 years from the retiree provision. Can you explain to me exactly how you're going to determine companies' gains and how you're going to facilitate collecting this?

Ms. FEDER. Mr. Stark, it is my understanding that we continue to review that option or that procedure. So I would not like to attest to a specific on that. But I think that, as we have explored that area, we have found that there is a capacity to assess the short- and long-term savings that——

Chairman STARK. I'm sure.

Ms. FEDER. So it is drawing upon that database——

Chairman STARK. Let me try this with you then. This is for people 55 to 65, correct? Let's just assume on the average it's going to be a 10-year obligation; maybe it's going to be shorter.

Ms. FEDER. Excuse me, you mean in terms of——

Chairman STARK. What we're assuming is what the Federal assumption of liability will be for these people. So on an individual person who takes early retirement at 55—and let's skip the idea for a minute that it's 80 percent but it's what we're giving to the companies—every premium in every plan, I believe, is not age-sensitive. That in the period of 55 to 65, although plan premiums may vary, it's going to be the same premium 55 to 65.

Ms. FEDER. As for 45 and 35.

Chairman STARK. Yes. Now that means that for 10 years, if we take your estimate—and that doesn't make any difference where it is, but just to argue for a minute, let us assume it is $1,800 per individual. We're going to relieve the company of $18,000 in constant dollars, not including interest rates—not present value but purely flat value. If we only collect 50 percent from the company

for 3 years, we are really only recapturing 15 percent of the benefit, aren't we?

Ms. FEDER. Again, I would prefer to explore that later when we've fully worked it out. But my understanding of our objective is that——

Chairman STARK. But under the hypothetical that I gave you that would only be 15 percent, wouldn't it?

Ms. FEDER. I don't know that I can attest to that because the objective is, if we proceed in this way, is to recapture a portion of the present value and a structure of the long-term savings. So exactly how that formula—I can only answer it after we——

Chairman STARK. So what you're saying is the 3 years is there to recapture a certain percentage of the present value, but that percentage——

Ms. FEDER. Of the downstream savings.

Chairman STARK. But that percentage is not 50 percent. The 50 percent only relates to the 3-year window. That's what it says.

Ms. FEDER. I believe so. But the structuring of the formula is intended to capture the present value of the long-term savings.

Chairman STARK. Could you submit for me later, if we were going to capture 50 percent of the current value, which is how all the corporations have had to put it on their balance sheets, then what would——

Ms. FEDER. I'd be happy to explore that.

Chairman STARK. That would be interesting in the sense of where we go there.

How will the individual mandates be enforced?

Ms. FEDER. Most individuals we expect to have covered through their workplace, so that enrollment is readily automatic.

Chairman STARK. What about the 37 million uninsured now?

Ms. FEDER. As you well know, many of them are working. But you mean the people who are not working, and that is the more complicated task. As I indicated earlier, those people are entitled to coverage when they appear for service. It is that point at which they are identified and then it is the job of the alliance to obtain their contributions with back contributions as——

Chairman STARK. Sell their blood? What did you have in mind?

Ms. FEDER. I certainly would not prescribe that method. The issue is that if there's an individual who has no resources, there are no resources and we would not attempt to get them.

Chairman STARK. How would you find out?

Ms. FEDER. Essentially that becomes a part of the alliance's responsibility in dealing with the individual.

Chairman STARK. So the alliance will have to have enough of a staff to get a balance sheet and track down the history of people who come into emergency rooms without the card, correct?

Ms. FEDER. Individuals will be responsible for dealing with the alliance in that respect.

Chairman STARK. No, the other way around. These individuals have already shown that they are not going to deal with the alliance. They may have skipped on parole or a variety of things. You're saying then the alliance will have to collect.

Ms. FEDER. That's correct.

Chairman STARK. I see. So you're to enforce the individual mandate in the last analysis through the alliance; there will have to be an enforcement mechanism.

Ms. FEDER. Through the alliance, that's correct. With again, the State authority behind it as needed.

Chairman STARK. But if the alliance then is not a State entity, as they have the option of not being, they could be a cooperative nonprofit corporation.

Ms. FEDER. They do have access though to State authorities for——

Chairman STARK. So you would give them police powers to enforce the collection.

Ms. FEDER. The State does that.

Chairman STARK. Like they do for child support payments.

Ms. FEDER. I'm loathe to make an analogy. But essentially, the State police powers are available to them.

Chairman STARK. Now it's my understanding that even after the cost reforms are instituted the administration assumes that private insurance overhead will average about 13.5 percent. I presume that the administration does not intend to pay commissions for that type of sales cost; is that correct?

Ms. FEDER. That's correct.

Chairman STARK. So no insurance agent will be getting any fees or commissions even if he or she currently has large groups under contract; is that correct?

Ms. FEDER. The loading factor you are talking about is not based on——

Chairman STARK. So the 13.5 percent is after cutting out the commissions. Medicare has an overhead rate of about 3 percent. Can you tell me why we should use scarce Federal dollars to subsidize the cost of private insurance, profit margins, marketing, to the tune of 10 percent of what may be $900 billion a year. As I see it, that's a $90 billion subsidy to private insurance companies. Is there a good reason to give them that money?

Ms. FEDER. I would argue that there is, but it is not to go to profit margins. As we discussed earlier——

Chairman STARK. How do you prevent that?

Ms. FEDER. Let me talk about where I think it's going to go essentially and then talk about why it will go there. We are talking about, in this reform, major changes in the delivery system, which we believe are highly desirable. We believe that takes an investment of resources in the development of plans that can, in fact, deliver coordinated, comprehensive quality care. That is an investment, and that is a very different endeavor from what is currently going on in the administration of the Medicare program. So in that sense we're comparing apples and oranges.

Chairman STARK. Wait a minute. I'm missing something here. Kaiser won't have to invest a nickel in Alameda County. They already represent 500,000 people and they're building whatever hospitals they're building now, and they take care of them just fine. What do you anticipate that Kaiser will invest in that they don't invest in now?

Ms. FEDER. No, Kaiser already does invest. But we expect——

Chairman STARK. So you feel that if we give Kaiser 10 percent extra, that's profit, isn't it?

Ms. FEDER. No, what we've done, when we calculate the administrative cost factor essentially what we are doing is estimating, based on experience, what we think the average administrative cost will be. We are not guaranteeing that payment to anyone. We are assuming it in our estimates and think it is reasonable given the investment in delivery reform that many plans will undertake.

Chairman STARK. Have you made an estimate as to what you think it would cost if the same services were provided under Medicare?

Ms. FEDER. I think that what we would have to take into account in that respect is what would be invested again in the development of networks and organized delivery.

Chairman STARK. But Kaiser is under Medicare now so they've invested under it. I'm just wondering, do you feel comfortable that you'd burn up 10 percent, or $90 billion, in Medicare or—wouldn't you say if we could save even half of that, or $45 billion a year, that would be a savings worth examining?

Ms. FEDER. I think any savings are worth examining. But at the same time——

Chairman STARK. But you haven't examined that in your——

Ms. FEDER. Not the specifics of that, but I imagine that if you wish, for the record we could explain to you what we have used as evidence for it assuming this loading factor.

Chairman STARK. Not that study that was done in Rhode Island, please. Don't insult me.

Ms. FEDER. I don't think Rhode Island offers that experience, so I think we're looking at other——

Chairman STARK. There was a study done on hospitals in Rhode Island that is seriously disputed by anybody who has any knowledge of health care policy on the theory that 40 percent of the overhead of these hospitals was attributed to Medicare and that's bunk and you know it.

Ms. FEDER. The evidence that I was referring to was to look at what we've assumed about administrative costs in a new system and why it is that we have included this as——

Chairman STARK. It would make sense to you then to suggest that if, in fact, Medicare could provide this administrative cost at 3 percent there's no good reason to give, for the same services, 13.5 percent to private insurance companies, is there?

Ms. FEDER. Again, I think that we need to make a distinction. Essentially the question, when we're looking at this 13.5 percent, that's looking at the administrative costs of a plan.

Chairman STARK. No, you said it's private insurance overhead.

Ms. FEDER. Yes, of plans. That's what I meant, of private insurance plans. So that essentially we would look at not only the 3 percent that is Medicare administrative costs, but also the costs in Kaiser or like plans.

Chairman STARK. That's in the 3 percent that Medicare now spends. We get that free. I mean, we get a net premium to Kaiser. We are administering this plan and it costs 3 percent. Now if you're talking about 13.5 percent——

Ms. FEDER. I guess the question is—I mean, we know that the enrollment of Medicare beneficiaries in Kaiser-like plans is quite limited for reasons we both——

Chairman STARK. Right, because they choose not to.

Ms. FEDER. I said for reasons we both understand. But again, we are talking about a far broader issue. When we do our administrative estimates, they are affecting a far broader population of plans of all kinds.

Chairman STARK. But still, Medicare encompasses the broadest of the broad. It encompasses every State and every citizen in the United States—almost every citizen over 65, and it still does it at 3 percent. You keep cranking up 13.5 percent, and I'm saying you're suggesting a way to waste $90 billion a year.

Ms. FEDER. The only issue that we have, I think, is whether the investment in developing new delivery systems is an investment worth——

Chairman STARK. But you can't separate that out of the 13.5 percent, you never have.

Ms. FEDER. I can because of the standards to which I'm holding health care plans.

Chairman STARK. So let me ask you this. If and when this comes down the pike, I'll spot you whatever you're going to have them invest in a new delivery system, because there are no new delivery systems that you have that don't already exist. So all you're taking is some pretty good delivery systems and saying, that's what we ought to achieve. So in your 239 pages, there are no new delivery systems that don't exist in one form or another in the United States today.

If when we're done and Medicare can do it for 5 percent less and save the taxpayers $45 billion a year, would you then stipulate that we should continue to do it through Medicare? What reason would you give not to use that method? If we can set aside the money for the new system development and still do it for significantly less, should we not continue through Medicare?

Ms. FEDER. I just want to clarify because I'm not talking about setting aside dollars for new system development.

Chairman STARK. No, I was spotting you that to get that out of this spread of 10 percent. I said, I could take the 10 percent, do whatever you could dream up in new systems and still have $45 or $50 billion left.

Ms. FEDER. It is our view that we want to build on a private system. But I would——

Chairman STARK. You want a new system.

Ms. FEDER. And that we have changes in the incentives and the accountability that move in the directions that we've described, and that that is the best way to promote delivery. But we are happy to explore all of that with you, Mr. Stark.

Chairman STARK. That's good. But you haven't yet explored it.

Ms. FEDER. That particular option we have not.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I would suggest you already have a methodology in your plan to deal with the money not going to profit. That is, draw a line and put an arrow on it and

say that it doesn't go to profit and that will solve the problem for you.

Back to the discussion of how people get picked up in this plan. When I heard you outline it, it sounded to me like an awfully callous way to deal with a population which has already been unfairly treated for a long time. Those who are not now covered or who don't have plans are going to get their national security card the President held up at the joint session of Congress only when they bump into the system? If somebody gets hit by a car and they're taken to an emergency ward, then they get put into the system.

Questions to Dr. Shalala about illegals revealed the fund you're going to have, because the President said that illegal residents are going to be treated differently than legal aliens. I hope—now this is a Republican talking, that if we have a plan which promises universal coverage for all, and I believe any plan that passes will have that as a component—that we touch these people in the system a number of different ways.

Ms. FEDER. Absolutely.

Mr. THOMAS. Through IRS. Put an informational sheet inside their tax returns. There are a number of ways that the Federal Government can get out information and resources so that these people don't have to wait until they're hit by a car and they come into an emergency ward to get it. Now I know you didn't mean to say that, but you said that they get the card when they come in contact with the structure. Unfortunately, that's the way people come in contact with the structure often times.

Ms. FEDER. No. I'm glad you gave me the opportunity to clarify because I think that what we are endeavoring to do is to be humane and also to ensure providers the resources to serve people whether or not they have enrolled, holding aside the undocumented immigrants. That's a separate issue. So we indeed intend to reach people in a number of ways. And when I said absolutely, what I was referring to is the outreach effort to which we are committed through our public health investments to ensure the availability of services and full participation. This is what I've described as a last resort option.

Mr. THOMAS. But I think we ought to use the full resources of the Federal Government, and that goes beyond any of the health care structure.

On page 93, when you talk about covered expenditures, you say, health care expenditures covered by the budget include premiums paid to cover the guaranteed comprehensive benefit package whether paid by employers, employees, or individuals. Medicare and Medicaid expenditures are included under separate budgets. My assumption is that CHAMPUS and veterans health benefits are also under separate budgets.

How do you envision a global budget dealing with your ordinary person, your Medicare person, your civilian military person or your veterans person, being integrated through an alliance? If they're under separate budgets, how do we guarantee coverage? One of my concerns today is that every time we decide to do something about cutting the Federal budget we begin carving out areas that we don't touch, the veterans or Social Security or the rest.

It appears to me that if you package the separate budgets with Medicare, veterans, CHAMPUS, and others that those will have a positive inducement to keep them high. I mean, they almost always win when you put a vote up. The ordinary person's fund as a separate budget may, in fact, get cut so much that within the alliances the ordinary person is subsidizing these other budgets. Do you envision any linkage of all of these separate budgets that form the funds available to an alliance?

Ms. FEDER. I think that the linkages come from our overall approach to restructuring the delivery system. If you look at each of the proposals, whether it's for veterans, or for defense, or for the Indian Health Service, for various components you will see that we are moving all aspects of the system toward health plans and toward choices in the alliance. As we do that, I think that we are integrating under a similar approach.

Mr. THOMAS. From the political end, having experienced an attempt to try to keep separate tracks uniform, I would feel much more comfortable if the answer was that we ought to have a single delivery system for all Americans structured in a way for choice and quality. One that includes the seniors, the civilian military, the veterans and all the rest, under a single budget so that whenever we make a decision that affects one group, it affects all. I think that's the only way we're ever going to be able to achieve those controls.

I just personally want to say thank you very much. There is an awful lot we've still got to understand. I do hope you folks hustle your specifics to us because then we can have substantive discussions over the content and then talk about changes that make sense because that's the only way we're really going to move forward. But thank you very much for your testimony.

Ms. FEDER. Thank you, Mr. Thomas.

Chairman STARK. Judy, I'm going to ask you later, just so in between you can think of explaining to me something new that is in your plan, if your staff behind you might find a page reference in 239 that outlines a plan that does not now exist in the United States, or even a type of plan, that would be interesting. There's five or six people there with that book, if they can just find a page referring to a plan that we have had no experience with short of HIPCs, I'd like to let you outline that.

The other question that I'd——

Ms. FEDER. I'm sorry, Mr. Stark, did you want me to look at something now?

Chairman STARK. No, I was going to ask your staff to do that because you can't look and answer at the same time. I don't think that's fair. We had talked about new delivery systems and this chair is skeptical that there are any new delivery systems that anybody has dreamed up that aren't just rehashes of some system that exists. Therefore, we could look at them and determine what their overhead might be, so we're not dealing in the abstract.

One abstract area, however, that we are dealing with which is critical is that your cost containment strategy rests entirely, or its success rests entirely on the ability to come up with risk adjusters. You propose some long-term research for risk adjusters in Medicare and at the same time expect the national board to develop a risk

adjuster system for the entire population by 1995. We happen to know a lot more about the Medicare population than we do about the others so it seems to me you have your projects set backward in terms of timing.

The Academy of Actuaries and the Congressional Budget Office, both have suggested that there is no known way no to risk adjust. Without this tool, you can argue that maybe through the goodness of their hearts there will be cost containment. But without it, how would you prevent or how would you negate the strong incentive to avoid selection by insurance companies, which we have ample evidence that they do, to avoid the high cost population?

Ms. FEDER. I think that the risk adjustment is an important component of our proposal and that it is important not only to avoid risk selection, because we do have some enrollment and other measures to get everybody in, but also to assure adequate resources once people are in plans for the coverage of their care. We recognize that risk adjustment is something that needs further development. We do not have all the tools that we now need, so we are proceeding in steps and let me just briefly outline them for you.

Chairman STARK. What are you proceeding toward?

Ms. FEDER. In terms of moving toward better risk adjustment, we would proceed in our proposal to rely on better mechanisms as they become available, but we have to start somewhere.

I think that there is general agreement that we can adjust for gender and age and those kinds of characteristics and that we are able to do so. The real issue comes——

Chairman STARK. It is not your intention to adjust for age, is it or is it not?

Ms. FEDER. We have to distinguish in this respect the way in which money comes into a health plan, and there are no distinctions there. The premiums are the same regardless of age or gender. But when we are talking about the risk adjustments we're talking about the payouts to the plan, and that's where the health status issues are the greatest concern.

We believe that in the early years of a plan it is necessary to rely heavily on reinsurance mechanisms because we will be lacking in a system to precisely adjust for individual enrollees. We may be able to do somewhat better than we do now, but we need a reinsurance mechanism.

Chairman STARK. There is a reinsurance segment in here?

Ms. FEDER. Yes, that is the mechanism that we intend to use in the earlier years precisely to address the concerns that you have in mind.

Chairman STARK. Who will run that?

Ms. FEDER. The reinsurance system is established by the State.

Chairman STARK. All right.

Ms. FEDER. In terms of developing the longer run——

Chairman STARK. Is that specified here as part of the alliance requirement? I've read that thing a couple of times and I'm not sure.

Ms. FEDER. It's part of the State plan.

Chairman STARK. Just that there will be reinsurance.

Ms. FEDER. I would share with you that it was not a heading in the document and that may be why you didn't see it.

Chairman STARK. Yes, I just read the big type, and look at the pictures.

Ms. FEDER. In terms of the longer term and the concerns you raise with respect to the Academy of Actuaries, in our meetings with them one of the concerns has been the adequacy of data to adjust adequately for health status. A part of our investment in the new system involves having data on a population in which now everyone is covered, everybody enrolled. We don't have that right now. So we have a capacity to have far better data than we have ever had.

Chairman STARK. How much do you think that's going to cost? Not much, is it?

Ms. FEDER. Actually we include—I can't give you the dollar figure right now, but we have looked at that extensively and are including it in our estimates. But it essentially provides the foundation for looking at people's prior health services use which is the better——

Chairman STARK. But we're getting a tad off. I think I've heard that we're going to move toward risk adjustment. But without it there's no cost containment. I mean, your own cost containment plan relies on risk adjustment.

Ms. FEDER. No, I don't agree that there's no cost containment without it. What I believe is that we have to prevent against adverse selection, we have to prevent against profit by discriminating against high risk. That's what you're saying.

Chairman STARK. Yes, but we don't even know how to do that.

Ms. FEDER. I think that we do do that with respect to our—we have an enrollment mechanism that ensures that plans cannot discriminate at enrollment.

Chairman STARK. How do you ensure that?

Ms. FEDER. Because in today's market——

Chairman STARK. How do you ensure that specifically?

Ms. FEDER. I think that we do that through a centralized enrollment mechanism, that it's done at the workplace, or at an alliance. It is not done by the plan on a separate basis. So people are choosing——

Chairman STARK. So you are relying on random selection by the beneficiaries to prevent——

Ms. FEDER. What I'm saying is that the plan is not in a position to prevent people in that enrollment——

Chairman STARK. Are they in a position to advertise?

Ms. FEDER. They are in a position to advertise.

Chairman STARK. And you don't think that that would lead to risk selection?

Ms. FEDER. I think that it has an effect, but I think it could be——

Chairman STARK. Do you think there would be any other reason for these——

Ms. FEDER. No, what I think is very different from today is essentially that the information, whatever advertising goes on there, is also objective information provided by the alliance.

Chairman STARK. There's what?

Ms. FEDER. There is objective information provided by the alliance.

Chairman STARK. And you think the citizens will pay any attention to that?

Ms. FEDER. I do.

Chairman STARK. And that they won't look at these television ads and listen to Ed McMahon and go running into what——

Ms. FEDER. I don't think ads are inconsequential but I do believe that objective information——

Chairman STARK. How well do you think, for example, antiredlining laws have worked in the insurance industry in this country thus far?

Ms. FEDER. I think that we need major changes in the insurance market and that's why we're doing it.

Chairman STARK. In banking we have various strenuous reporting and antiredlining laws in banking. It doesn't work. These companies are bright and they made all their money for the past 20 or 30 years by avoiding risk.

So you are suggesting that you have a way to prevent risk selection.

Ms. FEDER. What I believe is that we need an armament of tools and that we are developing that full array.

Chairman STARK. And if it doesn't work then we're seriously underfunded.

Ms. FEDER. No, I don't agree that we're underfunded. I don't think that that's—I mean, we would have to explore that further. I'm not sure what your issue is there. I don't believe that we're underfunded. I believe that we need these mechanisms to ensure the availability of all plans to all people and to ensure the availability of resources to serve them where they are. I believe that we will develop increasingly refined tools to do that, but that we have a strategy for working on it in the immediate term.

Chairman STARK. I think we understand the general concept of low-income subsidies to cover premiums. But can you describe the subsidy schedule for low-income individuals?

Ms. FEDER. As I outlined in my initial statement, what I can say is that we are talking about subsidizing the family share of the premium up to 150 percent of poverty. The gradation within that range is not something I can specify now, in part because we've heard a lot of comments about——

Chairman STARK. Is that subsidy to low incomes individuals intended to be an entitlement?

Ms. FEDER. Yes.

Chairman STARK. If it is a Federal entitlement, how will the Federal entitlement be administered?

Ms. FEDER. People will be guaranteed that they will spend no more than they are obligated to under a schedule.

Chairman STARK. And the other end of that guaranty is that they will receive a minimum package of benefits?

Ms. FEDER. A comprehensive package of benefits as guaranteed.

Chairman STARK. So there is indeed a Federal entitlement to low-income individuals that they will be OK. Now many of those low-income beneficiaries, particularly pregnant women and children, currently receive benefits that are not covered under the proposed standard benefit package. Does the plan do anything to pro-

tect these benefits or will the Medicaid-eligible low-income population simply experience a reduction in benefits?

Ms. FEDER. First, I should state that our objective here is to see that these individuals, like others in our society, are no worse off under this plan than they are today.

Chairman STARK. But they are in the plan as it is described in document 239.

Ms. FEDER. Let me talk about the issues, if I may. The document, what the draft plan describes is that wraparound benefits in Medicaid, and of particular concern here are, I think, some rehabilitation services and——

Chairman STARK. No, of particular concern are pregnant women and children. You can take other benefits as well, but let's talk about prenatal care and postpartum care.

Ms. FEDER. I think that it's important as we look at this issue, which I would agree with you is an important issue and worthy of our attention, that many of the benefits that are now provided by Medicaid to pregnant women and children are included in the guaranteed package. So what we are concerned about here are benefits that may not be. So for that population——

Chairman STARK. That are not. Not may not be, but are currently not.

Ms. FEDER. That are not, that's correct. So then those benefits are—for that population we are talking about, I think, outreach services, transportation services, and services of that nature. For children we are also concerned, and people with disabilities, that's why I raised the rehabilitation issue.

As we've currently structured it or as you see the plan in the draft document, we have those wraparound services for people who are on cash assistance. What is at issue is what happens to people who now get those benefits who are not on cash assistance.

Chairman STARK. Yes, that is of interest.

Ms. FEDER. Let me describe what is in the plan and then talk—or just state that we are continuing to work on that issue. What is in the plan is a continued investment in public health programs that include maternal and child health centers that do provide some of these services as well as community health centers, and that's important. We also have in the long-term care plan, the home and community-based services we discussed, an array of these services. The concern is whether there are some gaps for people with lesser disabilities than are covered in that long-term plan.

Chairman STARK. And for pregnant women and children. And there are gaps, are there not?

Ms. FEDER. There are services that are not covered by the guaranteed package to which Medicaid recipients are currently entitled. We continue to explore revisions in the draft document so that people are not made worse off as we move forward to the new system, recognizing that many of the changes we do propose by integrating them into a mainstream delivery system would make them in many ways better off than they are today.

Chairman STARK. We had the National Association of Manufacturers, the U.S. Chamber, and an alliance group here that purports to represent the 1,000 largest industrial concerns in the Nation. It was their understanding, although this is not a complete poll, but

the opinion of those experts, that they did not anticipate that any large employers of 5,000 workers or more would elect to become a corporate alliance. And I've heard some say maybe 100 corporations will.

If there is minor, minimal, or no participation in the corporate alliances, does that have any effect on the plan? For example, what I'd be concerned about is the proposal to add a 1 or 2 percent extra tax on these corporate alliances to pay for some low-income and uncompensated care.

Ms. FEDER. Academic health centers.

Chairman STARK. Yes. If there aren't any corporate alliances what are you going to do?

Ms. FEDER. I think that the first question, as in all others, is to look at what we think actually will occur.

Chairman STARK. All right, but let's assume under my—that they don't join.

Ms. FEDER. What I would say as we review the estimates is that we need to be certain that we have contingencies that make certain that guarantees are available.

Chairman STARK. So we'd have to find other sources of revenue then to pick up for that risk.

Ms. FEDER. Actually on this score if they come into the—let me rethink that one, because essentially if they come into the alliance then essentially we will be getting the resources for many of those activities by virtue of their participation in the regional alliance. So it may well be that we have——

Chairman STARK. You just have to increase the premium on everybody.

Ms. FEDER. No, I don't think that. Essentially, for example, when we look at their contributions to academic health centers, if they're outside and we are taking from premiums some dollars to create a pool of funding for that purpose. If they're outside, they're not contributing to that funding. So that's a way that we get their funds.

If they're in the alliance then they will be contributing to that funding. So I think that we would look at all of that.

Chairman STARK. So it doesn't make much difference what you're saying with regard to whether they join or not.

Ms. FEDER. Well, I would want to examine it, but I think that there are some contributions they would be making if they were in that they would not be making otherwise.

Chairman STARK. Large employers who join the regional alliance pay a risk adjusted rate, and they won't pay the average rate until 9 years after joining the regional alliance; is that correct? How will these corporations calculate the premium they'll be expected to pay if they join the regional alliance?

Ms. FEDER. Essentially we're looking at rating them based on their current experience and their demographics. So we would expect them to pay a rate that is quite similar to the rate they currently pay since that's how they are rated. Why don't we provide you the details on that for the record, Mr. Stark?

Chairman STARK. Yes, if that's in the details. It's a concern and——

Ms. FEDER. Can you elaborate on the concern so that we can respond appropriately?

Chairman STARK. One, they have trouble calculating it. And two, if there's an assumption that a large number of corporations are going to kick in this extra 1 or 2 percent and they don't, then how does that reflect on the others who are going to pay and what you anticipated that they would pay? That's troublesome.

Ms. FEDER. Then why don't we provide you more information on that.

Chairman STARK. I'd appreciate that. I've kept you overtime and you have more important things to go on to now, so why don't I thank you very much. I'm sure we'll be spending a good bit of time together as we get the details of the plan.

Ms. FEDER. I look forward to it. Thank you, Mr. Stark.

Chairman STARK. The committee is adjourned.

[Whereupon, at 1:50 p.m., the hearing was adjourned to reconvene at 10 a.m., Friday, October 15, 1993.]

PRESIDENT'S HEALTH CARE REFORM

FRIDAY, OCTOBER 15, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:40 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

Chairman STARK. Good morning.

Today we will continue our hearing on the administration's health reform proposal featuring witnesses from the Department of Health and Human Services. Yesterday we focused only on issues concerning State and Federal roles, corporate and regional alliances, the National Health Board, and heavens knows how many other issues, including issues affecting low-income individuals and long-term care.

Today we will begin by focusing on two general areas, the proposed methodology for controlling the rate of growth in public and private health spending and issues involving Medicare beneficiaries, benefits and the future of the Medicare program.

We are pleased to welcome Bruce Vladeck to the subcommittee. He is the administrator of Health Care Financing Administration, affectionately known as HCFA. He is an experienced and noted expert in health financing issues. He has had many years in the public and private sector. He is the designated guardian of the Medicare program and a sweeter and kinder junk yard dog I have never met.

We did the right thing yesterday and his colleague, Dr. Judith Feder, wanted to come back for more. She is accompanying him.

At this time, I recognize any Members that have an opening statement.

If not, Bruce, why don't you proceed to enlighten us in any manner you are comfortable.

STATEMENT OF BRUCE C. VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, ACCOMPANIED BY JUDITH FEDER, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. VLADECK. Thank you, Mr. Chairman.

Good morning. As you all know it has been my privilege to appear before this Subcommittee on a number of occasions in the past, but I am approaching today's hearing with a special sense of

excitement and anticipation. To paraphrase the President, I believe we are embarked on a truly historic journey toward health care reform and I very much look forward to accompanying you on it.

I am very pleased to be accompanied by Dr. Feder. As you know from yesterday, she knows more about all of these things than anyone else and I am always glad to have her with me in case Members have particularly difficult questions. She has been a mentor and teacher of mine for many years even though she is younger than I am.

Chairman STARK. I didn't want to interrupt Judy yesterday, but those mikes have to almost be swallowed to be audible. It would help the reporter and everybody. Thank you very much.

Mr. VLADECK. I do have a statement which we have made available to you and will submit for the record. If I may make a few brief introductory remarks.

Chairman STARK. Without objection.

Mr. VLADECK. The President's health security plan will restructure our current health system so that all Americans will have access to quality health care at a price they and the Nation can afford. The plan builds on a foundation of what works in the existing system and seeks to fix those parts of the system that are broken.

We start with the proposition that our Nation has the resources to meet the health care needs of all our citizens if we spend those dollars more wisely. It is the lack of rational spending in today's system with health care costs growing at twice the rate of growth in the system as a whole that cannot be sustained and that we must address in health care reform.

We need health care reforms as an economic strategy—to bring the growth in health care in line with that of the economy as a whole—so that we may invest our resources in areas other than health care. We believe the President's plan does this.

Yesterday you heard testimony on many aspects of the system from the person who knows most about those aspects. Today I have been asked to focus on how we propose to finance the President's health security plan and on the relationship between the newly reformed system and Medicare, including the new Medicare drug benefit.

The new system is financed primarily from three sources. The most important—and it is worthy of special emphasis because it tends to get lost—are employer and individual premiums. Two-thirds of the funds we are seeking to raise will be from premiums.

We believe this is both the fair approach to financing, in that it asks responsibility of everybody involved, and also the approach that builds most closely on the existing system. Under the President's proposal, all employers will contribute to the purchase of health care coverage for their employees by paying at least 80 percent of the weighted average premium for coverage in the regional alliances or in corporate alliances, with individuals and families responsible for the remainder of the premium for the plan of their choice.

I also would like to emphasize, because it is quite central to the proposal and has not received as much attention as it might, that no one in the system will pay a higher premium because of prior

illness history, age, gender, race, occupation, or any other personal characteristic.

Community rating is really at the heart of much of the reform we seek to accomplish, and because of it each family will be assured that a major illness or a change in family status will not result in the loss of coverage or higher premiums in the future.

The second source of funding for the President's proposal are reductions in the rate of increase in private and public health spending. The private side we expect will see immediate cost savings upon passage of the plan as a result of reform of the insurance markets, administrative simplification, and strengthening of penalties and of investigatorial resources relative to fraud and abuse.

The most substantial savings will be achieved through the working of competition established under the new system. The President's plan makes it possible for families, small businesses, and individuals to band together to get the same clout as the largest buyers, allowing them to bargain for high quality care at affordable prices.

We expect that these incentives will lead to significant reductions in the rate of cost increase, but there will also be a national health care budget as a backstop by limiting the growth of premiums in regional alliances to a national inflation factor, which itself will be tied to the Consumer Price Index.

We expect further that uniform administrative procedures will cut significant waste and overhead from the health care system. We have proposed—in an area in which this subcommittee has been active in the past—standardization of forms and automation of transactions both to make the system work more efficiently and to make it work less expensively.

We are very confident of our ability to achieve significant one-time savings from the reduction in administrative overhead resulting from reform of the insurance market and from the implementation of administrative streamlining. In the long run savings will be generated largely by improvements in productivity in the health care system.

Under the plan, providers will have to examine ways to make their systems and their delivery of care more efficient without sacrificing quality. Business as usual will no longer be acceptable or profitable. We have enough experience and enough examples to know that with the right incentives, the provider community can, in fact, respond positively.

Further, we think it would not be fair to ask Americans and employers to carry all the burden of financing a universal health care system without a promise from the Government to do its part in making the system as economically efficient as possible.

The President's plan—and just about every other plan that has been proposed for health care reform—recognizes that comprehensive reform of health care will make possible savings from reductions in the rate of cost increases in Medicare and Medicaid. When our bill is introduced, we will identify specific line-by-line savings in the Medicare program. What I want to emphasize today is that we expect between now and the year 2000—between fiscal 1996 and the year 2000—that the Medicare program will spend in excess

of $1.4 trillion and the savings we are talking about are relative to that entire aggregate.

Let me assure you, on an issue of great personal concern as well as policy concern to me, that the President has no intention of putting Medicare beneficiaries at risk. The President is committed to a strong Medicare program and, in fact, committed to enhancing the benefits of Medicare recipients as part of the plan. Unlike a budget reconciliation bill, the savings we are going to propose will take place in the context of reform of the entire system.

In the context of a plan that brings down private sector costs and improves the benefits available to Medicare beneficiaries, we believe we can achieve further Medicare savings without shifting costs or endangering beneficiary access.

Doing so will not only benefit the economy and the management of the Federal budget, but will also help us preserve the long-term integrity of the hospital insurance trust fund. Without such savings, it is hard to envision ways in which we could do that.

When we submit our list of savings, Mr. Chairman, you will see that a substantial proportion are the result of reducing or eliminating payments in the Medicare system that now either explicitly or implicitly subsidize providers who provide significant volumes of uncompensated services. Under universal coverage, presumably the cost to providers of such uncompensated care will be significantly reduced. We look forward to working with you on the details of that proposal and indeed on all our Medicare proposals.

In addition to Medicare savings, the President's plan will also produce very significant Medicaid savings by reductions in Medicaid disproportionate share classified payments to States and more importantly by integrating Medicare beneficiaries into the mainstream of the health insurance system where we anticipate the rates of cost growth will be significantly lower than has been experienced by Medicaid in recent years. There should also be substantial savings from other health programs.

The third source of funding for reforming the health care system in the President's proposal are the tax on tobacco and an assessment on corporate alliances. We believe it is appropriate to tax a product which contributes so greatly to health care costs. In addition, we believe that corporations which form their own alliances should pay their fair share of the costs of certain community-wide resources, particularly academic medical centers, the financing of which remains essential under the health care reform plan.

These three sources of funding, premiums, savings and new tobacco taxes and corporate revenues, will mostly be made available for three new categories of spending: what we need to spend in order to guarantee coverage for all Americans, particularly the Federal assistance for low-income individuals, small and low wage businesses and early retirees; the new Medicare prescription drug benefit and a new long-term care benefit; and public health initiatives which I will not address today.

Federal assistance for low-income persons, for nonworkers and for early retirees, will make insurance accessible for the millions who cannot now afford health insurance. Depending on their incomes, those individuals will have their premiums paid in whole or in part by the Federal Government.

It is critical, as you know, that we provide financial protection for small businesses and other low-wage employers. That is why the plan guarantees that the required employer contribution in regional alliances will not exceed 7.9 percent of payroll for any employer, nor exceed 3.5 percent of payroll for low-wage businesses with fewer than 50 employees, with a sliding scale between the 3.5 and 7.9 percent.

We also believe that the plan will significantly reduce the health care costs for employers who now provide insurance for their employees, which includes two-thirds of small businesses, by cutting administrative expenses, stabilizing the growth in health care spending, and targeting assistance to the smallest employers most in need of help. This means more money for other small businesses now providing coverage to hire workers, to increase compensation for existing workers, and to otherwise reinvest in their business.

A word or two about the Medicare prescription drug benefit. We believe it will have a major impact on the quality of care and quality of life for the elderly. Right now, the cost of outpatient prescription drugs forces many older Americans to choose between their medicines and other necessary expenses, like food or housing.

In addition, there are serious qualitative problems generated by the way in which many Medicare beneficiaries now receive their prescriptions or don't receive their prescription drugs. Making drugs financially accessible to the elderly will help eliminate preventable illnesses and unneeded hospital stays that can be the result either of going without a prescription necessary to keep someone healthy or from the use of duplicate interactive prescriptions.

As in the standard benefit package for all Americans, the Medicare drug benefit will cover all drugs, biological products and insulin approved by the Food and Drug Administration. The drug benefit will be incorporated into part B, so that beneficiaries will experience a modest increase in their Part B premium. There will also be a separate annual drug deductible of $250.

Like other Part B benefits, beneficiaries will be responsible for 20 percent coinsurance for prescription drugs. However, unlike other part B services, there will be a $1,000 annual limit on beneficiary out-of-pocket spending for prescription drugs.

The prescription drug program will benefit from the expertise and success we have developed in our current Medicaid drug program, which was the occasion of my last appearance before this subcommittee. Drug manufacturers will have to sign rebate agreements with the Secretary similar to those they now sign under Medicaid.

An additional rebate will be levied for drugs whose prices increase faster than the rate of inflation. For new drugs, the Secretary will have authority to negotiate with manufacturers for a discounted Medicare price.

I know there are concerns about the administration of this drug benefit. I want to assure members of this subcommittee that we are very comfortable with our track record in the Medicaid drug program since OBRA 1990 and we have developed a number of good working relationships with the manufacturers and with States.

We have established new data and reporting systems and we are implementing new billing and processing systems. This experience

and the growing Medicare experience with implementation of direct electronic on-line billing will permit us to employ on-line systems, not only for Medicare drug claims payment, but also for prior authorization and utilization review.

The Medicare program will continue to offer health security to America's elderly and disabled citizens. In addition, we believe it is important to provide Medicare beneficiaries with more choices. Consistent with the rest of the President's proposal, our commitment is to giving consumers as many choices of health care plans as we can manage. Thus, under the President's plan, workers who become eligible for Medicare at a time when they have been enrolled in an alliance plan may remain in the plan if they choose. For those who choose to remain in the plans, we will make a fixed per capita payment to an alliance.

For beneficiaries who choose the Medicare program, we hope to expand their opportunities to participate in managed care, both through improvement in our managed care programs that are currently in existence and by the development of new options as well.

Through these options, we hope beneficiaries can receive Medicare benefits and additional benefits for less out-of-pocket expense than they are now paying for medigap policies.

In conclusion, Mr. Chairman, the President's health security plan provides an ambitious agenda for restructuring our Nation's health care system at a price we can afford without compromising quality or limiting the availability of necessary services.

We have set some very hard objectives and lofty goals, but goals I think we can agree are critical to the health and welfare of our Nation. Both institutionally and personally, I very much look forward to working with you and your colleagues in the months ahead to forge a consensus on health care reform that promotes the improved health status of all our citizens while strengthening our national productivity.

Thank you very much.

[The prepared statement follows:]

TESTIMONY OF BRUCE C. VLADECK
ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and Members of the Subcommittee:

As you know, it's been my privilege to appear before this Subcommittee on a number of occasions in the past. But I approach today's hearing with a special sense of excitement and anticipation. I believe we have embarked on a truly historic journey, as the President said, and I look forward to accompanying all of you on it.

The President's Health Care Security Plan will restructure our current health system so that all Americans will have access to quality health care at a price they and the nation can afford. The plan builds on a foundation of what works in the existing system and seeks to fix those parts of the system that are broken.

BACKGROUND

The First Lady and her task force have put forward a comprehensive proposal that will provide security, savings, quality, simplification, choice and responsibility -- six objectives that must be achieved in health care reform.

The issues raised in health care reform are complex and difficult to resolve. We continue to work on policy and details of the President's plan, and we value your advice and counsel as we work through the nuts and bolts of the system.

At the outset, we must agree that our nation has the resources to meet the health care needs of all our citizens, **if we spend our health dollars wisely**. It is the lack of rational spending in today's system, with health care costs growing at twice the rate

of the domestic economy, that cannot be sustained and must be dealt with in any system of health care reform.

We need health care reform as an economic strategy -- to bring the growth in health care in line with overall economic growth, and to be able to invest our resources in areas other than health care. We need to fix the current system's incentives in order to increase competition, improve consumer choice, reduce administrative costs, increase the negotiating power of small businesses and individuals, and impose budget discipline. The President has proposed a plan to do this.

Yesterday you heard testimony from Dr. Feder on the rationale for health care reform, the overall structure for reform in the President's plan, and the President's long-term care program. Today, I will focus on how we propose to finance the President's Health Security Plan and what this financing will pay for. I will discuss the responsibilities of individuals and their employers and how we plan to bring the growth in health care spending in line with the rest of the economy. And I will describe the relationship between the newly reformed health system and Medicare, including the new Medicare prescription drug benefit.

FINANCING

There are three primary sources of private and public funding that will support the President's plan: premiums, savings, and tax revenues.

Premiums

The **first** source of funding, employer and individual premiums, will raise two-thirds of the funds needed to pay for health security for all Americans. We believe this is a fair approach to financing: one that asks responsibility of everyone involved. In today's health care system, those of us who are insured are paying the price for those who are not -- this must change. That is why we propose that people who do not have health insurance and companies who do not provide insurance to their employees take responsibility and contribute to the system.

Under the President's premium proposal, all employers will contribute to the purchase of health care coverage for their employees by paying at least 80 percent of the weighted-average premium for health insurance coverage in the regional alliances or in their corporate alliance. For part time employees, the employer contribution will be pro-rated. Of course, if an employer wishes, it can choose to pay up to the entire premium for its employees, as some do now. In addition to making universal coverage possible, requiring all businesses to contribute toward health care coverage will provide a level playing field, removing the incentive to cut back on health care benefits as a way to help the bottom line.

After the employer pays its share, families and individuals will be responsible for the remainder of the premium for the plan of their choice. As for the nation's 37 million uninsured individuals and families who can't afford health insurance -- 85 percent of whom are working people and their families -- we are going to make it possible for them to afford their fair share -- with discounts for low income workers and for those

persons who are not employed.

No one will pay a higher premium because of illness, age, sex, race, occupation or any other personal characteristic. This point has not received as much emphasis as it deserves. Because of community rating, each family will be assured that a major illness will not result in loss of coverage or higher premiums in the future.

Uncontrollable health care premiums will no longer be a point of anxiety for employers or their workers under our health care plan because a national heath care budget will ensure that health care costs do not grow faster than other sectors of the economy.

Savings in Health Care Expenditures

As a **second** source of funding for health care security, we are proposing reforms that will result in savings in private and public health spending.

Assuring access to health care for the previously uninsured or underinsured will by itself yield savings. Primary care for these newly insured people will move out of emergency rooms -- the most expensive and least appropriate sites for such care -- and preventable hospitalizations will decline. In this city, for example, poor children are hospitalized for asthma five to seven times as often as middle class children because they lack access to comprehensive outpatient care.

In addition, the private health care industry will see immediate cost savings upon

passage of the President's health care plan as a result of administrative simplification, reform of the insurance markets, and stiff penalties for fraud and abuse.

In Washington, we have heard countless grievances about the problems of **administering health care**. By establishing uniform administrative procedures, we will cut much of the overhead and waste from the health care system. Steps we're taking that will be of particular interest to this Subcommittee include:

- Development of standard forms for enrollment, billing, claims, medical records, and reimbursement. These forms will build on both Medicare and private sector models, and will save money and time by simplifying administration for consumers, providers, and health plans.

- Building upon what Medicare has accomplished in the last decade by reforming standards for automating insurance transactions which will help eliminate conflicting information, formats and definitions used by health care providers.

Fraud is yet another high-cost factor of our health care system. The President's plan increases the penalties for those who cheat the system and commits more investigative and prosecutorial resources to pursuing and ultimately deterring such behavior.

Our most substantial savings will be achieved through market-based forces which will aggressively control costs through negotiation and competition. The President's plan

will make it possible for families, small businesses, and individuals to band together to get the same clout as big businesses, allowing them to bargain for high quality care at affordable prices. We are encouraged by local reforms that have already headed in this direction.

Consumers will be able to review annual quality report cards and choose plans based on the value they get for their dollar. Each year, people will have the opportunity to say yea or nay to their health care plan. This will be a powerful mechanism for promoting efficiency and quality among health care insurers and providers.

While we expect that market incentives created by our health care reform plan will control costs, the national health care budget will serve as a backstop by limiting the growth of premiums in regional alliances to a national inflation factor anchored to the Consumer Price Index. The National Health Board will adjust the budget for each alliance to reflect unusual changes in the demographic and socio-economic characteristics of the population covered by the alliance.

The National Health Board will calculate a per capita premium target for each alliance using the national per capita baseline target as a reference point. For each alliance, the Board will adjust the national target for regional variation in health care spending and for rates of underinsurance and overinsurance. The Alliances then negotiate with health plans in order to meet the alliance premium target. If the target is exceeded, the amount above the target is recouped from plans in the alliance area.

We are well aware of the controversy that surrounds the savings figures in our plan. I want to assure the subcommittee of our ability to achieve significant one-time savings in the early years of this plan as well as long run savings from productivity improvement in the health system.

Significant health care expenditure reductions will result from eliminating the small group and non-group insurance market; from standardizing and streamlining hospital and physician reimbursement and reporting requirements; from consumers switching to lower cost plans; and from providers improving their productivity.

Under the President's health reform plan, providers will have to examine ways to make their systems more efficient, in the long run as well -- without sacrificing quality. "Business as usual" will no longer be acceptable -- or profitable. We already have many existing examples of how technology, quality improvements and heightened productivity can reduce costs and we have every reason to believe the health care sector will respond positively to incentives to reduce costs.

We know, for example, from our experience under the prospective payment system, that the more successful hospitals have learned to utilize their bed and equipment capacity more efficiently, to employ labor in more creative and productive ways, to manage inventories of supplies and medications much more economically, and -- perhaps most critically -- to work with their medical staffs to identify and eliminate practices and procedures that are wasteful and detrimental to high quality.

We have also seen, in the Medicare program and elsewhere, that the more heart surgery, cataract surgery, or AIDS treatment performed at a particular hospital, the lower the costs per case -- and the better the outcome. There are, in other words, significant and identifiable economies of scale in the treatment of many conditions.

And we've long known that the better managed HMOs use fewer specialty referrals, lab tests, and invasive procedures; and produce better care than typical fee-for-service practices.

For years doctors, nurses, and hospital administrators have been telling me -- as I'm sure they've told you -- that they could do things much more efficiently if only they weren't penalized economically for doing so. Under the President's plan, health plans and providers will finally have the right incentives to increase productivity, and we have plenty of experience that demonstrates their capacity to respond effectively.

It wouldn't be fair to ask Americans and their employers to carry the burden of financing a universal health care system without a promise from the government to do its part in making the system as economically efficient as possible.

Our plan -- and virtually every Democratic and Republican plan that has been proposed -- recognizes that with national health care reform, we can save money by lowering the rate of growth in Medicare and Medicaid. Our bill will identify specific, scorable, line-by-line savings in the Medicare program -- an amount comparable to the savings proposed by the Senate Republican plan, and less than the savings

called for by some single-payer proposals. And while the amount of our seven-year savings may seem high today, we must keep in mind they will be taken from a future base of $1.4 trillion in projected Medicare spending over the years 1996 to 2000.

Let me assure you that this President has no intention of putting Medicare beneficiaries at risk. The President is committed to a strong Medicare program and, in fact, Medicare recipients will see their benefits enhanced under our plan. Unlike a budget reconciliation bill, our savings will be a result of a thorough reform of the entire system in which everyone stands to gain. In the context of a plan that will bring down private sector costs, we can achieve Medicare savings without shifting costs or endangering beneficiaries' access to services. And reducing costs in both sectors of the economy will serve to improve the long-term integrity of the Medicare trust funds.

Shortly, Mr. Chairman, we will be submitting to you the specifics of these savings, and you will see that a substantial proportion are a result of reducing or eliminating payments that now address the financial pressures on providers created by uncompensated care. With universal coverage, uncompensated care will be substantially reduced. We will look to this subcommittee's expertise in the Medicare program and pledge to work closely with you in this area.

In addition to the savings in Medicare, the President's plan will also produce Medicaid savings by reducing Medicaid disproportionate share payments to States and by folding into the alliances the acute care portion of the Medicaid system. We

also anticipate substantial cost offsets from other federal health programs such as the Defense Department's health program and the Federal Employees Health Benefits program.

Health Tax on Tobacco and Corporate Assessment

As a third source of funding for reforming the health care system, we propose a tax on tobacco and an assessment on corporate alliances.

The President believes it is appropriate and necessary to tax a product which contributes so greatly to health care costs. It is our hope to discourage cigarette smoking, especially among adolescents, and promote good health. Some people call this a "sin" tax, we prefer to think of it as a "health" tax.

For additional revenues, corporations who choose to form their own health alliances will be asked to pay an assessment. Employers in the regional alliances will pay premiums that include a contribution toward the costs of biomedical research and health professions training incurred by our academic health centers. Because academic health centers are so critical to the continued high quality of our health care system, we believe it is fair to ask all payers -- including the self-insured employers -- to help support these investments.

SPENDING

The three sources of funding which I have just outlined -- premiums, savings, and new tobacco and corporate revenues -- will be mostly committed to three categories

of spending:

- Coverage for all Americans with discounts for low income individuals, small and low wage businesses, and early retirees,
- New long-term care and Medicare prescription drug benefits, and
- Public health initiatives.

Discounts for Low Income Individuals, Small and Low Wage Businesses, and Early Retirees

Discounts for low income individuals, small business, and early retirees will make insurance accessible for the millions who cannot now afford health insurance.

Discounts for low income workers and non-workers will make it possible for each to contribute their fair share. Individuals and families with incomes below 150 percent of the poverty line will have some or all of their share of the premium paid by the federal government based on their family income. Individuals who don't work or who work part time may be responsible for a portion of the employer share of the premium. The federal government will provide assistance to these individuals for this "employer" share of the premium if their non-wage income is below 250 percent of the poverty level. The federal government will pay the full premium for non-working individuals receiving cash assistance.

Early retirees are also eligible for health care coverage through regional alliances. They will pay only the 20 percent share they would have paid if employed and will be eligible for the discounts that are available for other people based on their income. In

cases where employer contracts to provide retiree health coverage exist -- employers will pay the individual's 20 percent share. The federal government will contribute the 80 percent share for all early retirees. People will be eligible for this early retirement assistance from the federal government if they are between the ages of 55 and 65, not employed, and have at least the minimum number of quarters of covered work under Social Security.

Small businesses and other low-wage employers in the regional alliances will receive financial protections as well. We guarantee that the required employer contribution in regional alliances will be no more than 7.9 percent of payroll for any employer. Special discounts will be provided for low wage businesses with fewer than 50 employees, limiting their payments to between 3.5 percent and 7.9 percent of payroll. Small employers with average wages of less than $10,000, for example, will have their premium contributions capped at 3.5 percent of payroll, while small firms with average wages of $24,000 will be capped at 7.9 percent.

Most small businesses now provide insurance for their employees. These firms are paying as much as 35 percent more than big businesses to cover health care for their workers. The President's plan will significantly reduce their health care costs by cutting administrative expenses, stabilizing the growth in health care spending, and targeting discounts to the smallest, lowest wage employers most in need of help. We are confident these reforms will lower costs for small employers who now provide insurance -- giving them more money to hire workers, pay existing workers higher wages, and otherwise invest in their business. So, discounts will help create jobs

and improve wages for small businesses that do provide health insurance.

For those small businesses who do not or cannot now provide coverage -- the reforms we have designed will make health care affordable and not burdensome. Our proposed market reforms will stop unfair insurance practices and reduce the overhead costs that are barriers to small business health coverage today. Small employers will be relieved of the burden of finding and administering their employee health benefits program. Our small employer discounts will significantly reduce financial costs. And finally, self-employed individuals will be permitted to deduct 100 percent of their premium contributions from their tax liabilities as are other employers.

New Benefits

The new benefits that will be financed by the President's plan include a new long-term care program and a Medicare prescription drug benefit.

Many elderly and disabled Americans must rely on their families if they wish to remain at home. And families often exhaust their savings trying to provide for disabled relatives. Our state-based **long-term care** program plan will improve security for those in need of long-term care and their families by easing this financial burden. The long-term care program was discussed in yesterday's hearing.

The Medicare prescription drug benefit will have a major impact on the quality of life of the elderly. Right now, drug costs force some older Americans to choose between food and medicine. Making prescription drugs financially accessible to the

elderly will help eliminate illnesses and unneeded hospital stays that are sometimes the result of going without a prescription necessary to keep an elderly person healthy.

As in the standard benefit package, the Medicare drug benefit will cover all drugs, biological products and insulin approved by the Food and Drug Administration. Since the drug benefit will be incorporated into Part B, Medicare beneficiaries will see an increase in their Part B premium. They will also have to meet an annual drug deductible of $250. Like other Part B benefits, beneficiaries are responsible for 20 percent coinsurance on all prescription drugs. Unlike other part B services, however, there is a $1,000 limit on beneficiary out-of-pocket spending.

The Medicare prescription drug program will benefit from the expertise and success we have already achieved in the current Medicaid drug program. Drug manufacturers will have to sign rebate agreements with the Secretary, similar to those they sign now under the Medicaid program. An additional rebate will be levied for drugs whose prices increase faster than the rate of inflation. For new drugs, the Secretary will have authority to negotiate with manufacturers for a discounted Medicare price. Medicare will cover any new drugs for which the Secretary and manufacturers can agree on a satisfactory price.

I should point out that we adopted this approach of rebates, discounts and negotiated prices because the pharmaceutical industry was adamantly opposed to Medicare's use of private sector strategies to hold down prescription drug costs. In

particular, the industry opposed Medicare's use of negotiated formularies which private plans will use to receive prescription discounts. Today, private hospitals and HMOs negotiate with manufacturers for price discounts in return for covering that manufacturer's drugs on their formulary. Because the pharmaceutical industry felt Medicare's large market share would distort the outcome of other market negotiations, we agreed to adopt the approach we did. However we will be pleased to continue discussions with this subcommittee and the industry on the most appropriate strategies for protecting the Medicare program and the taxpayer while assuring access to needed medications for the elderly and the disabled.

I know there has been concern about the administration of a Medicare prescription drug benefit. I want to assure the subcommittee that we have a good track record from experience in the Medicaid program with drug manufacturers and States in developing working relationships, establishing new data and reporting systems, and implementing billing and processing systems. The large volume of drug claims that will result from this benefit will be best handled by electronic on-line systems in pharmacies for drug utilization review and claims payment purposes. While complex, an electronic drug claims processing system is much more accessible now than 5 years ago, when we were working on the Medicare catastrophic drug benefit. Currently, Medicare leads the industry in electronic claims processing. The system will also facilitate the establishment of a drug utilization review program that will identify duplicative prescriptions or potential adverse reactions.

Options for Medicare Beneficiaries

Enhanced by the new drug benefit, the Medicare program will be strengthened and will continue to offer health security to America's elderly and disabled citizens. In addition, the President's plan improves upon the Medicare program by providing beneficiaries with more health care options than they've ever had before.

Beneficiaries who are employed, or whose spouses are employed, will receive their health care coverage through the Alliances. Employers will contribute the 80 percent of the average weighted premium and employees will contribute the remainder. Beneficiaries will be able to choose from among all the plans in their alliances and will be charged the same premium as everyone else.

Beneficiaries who become eligible for Medicare will be permitted to remain in the Alliance, if they choose. Plans may bid separately for these Medicare beneficiaries. For those who choose to remain in the Alliance, the Medicare program will make a fixed per capita payment to the Alliance. It is likely to be equivalent to what it would have paid if the beneficiary had enrolled in a Medicare risk plan. The beneficiary would make up the difference between the bid amount and the Medicare payment. Medicare eligible individuals in the Alliance may later choose to return to Medicare and remain enrolled there. Whether in the Alliance or in Medicare, we want our beneficiaries to have more coverage options as new plans develop.

For beneficiaries who choose Medicare, there will be expanded opportunities to participate in managed care. Within 3 years, all managed care plans in the alliances

must contract with the Medicare program. Through these plans beneficiaries may receive their Medicare benefits, and usually additional benefits, for significantly less than the cost of a Medigap policy.

States, such as those with single-payer systems, can apply to the Secretary for approval to integrate Medicare beneficiaries into their system. We will approve such requests only if we are satisfied that neither the beneficiaries nor the government will be financially worse off; that quality will be equal or better; and that at least one fee-for-service plan will be available to the beneficiary at no greater out-of pocket cost than they would pay under Medicare.

CONCLUSION

In conclusion, the President's Health Security Plan provides an ambitious agenda for restructuring our nation's health care system. The President's plan provides a unified system to cover all Americans, one that is built largely on the foundation of existing employer health coverage, with federal assistance for low income individuals and small businesses. And the price of doing this is a shared responsibility that we can afford without compromising quality or limiting the availability of necessary health care services.

The President's plan calls for financial responsibility, fiscal prudence and budgetary discipline in the way we set premium rates, select and pay for insurance coverage, and compensate providers for services they render. We will curb the dramatic growth of health care costs by linking cost containment controls in both the public and

private sectors. We have set hard objectives, but ones I think we can agree are critical to the health and welfare of our nation.

I look forward to working with you in the months ahead to forge a consensus on health care reform that promotes the improved health status of our citizens and strengthens our national productivity.

Chairman STARK. Thank you, Bruce.

There are a lot of questions. Let me just start with one that relates to Medicare and the plan. I have expressed to you some concerns that if we allow Medicare beneficiaries to enroll—let's first assume that people under 65, under the plan, will have a more generous benefit than Medicare beneficiaries largely by a change in co-pays and deductible. We can stipulate that all plans have the same benefits pretty much in terms of procedures. They will all take your appendix out.

The difference in cost of the plans is how much is the deductible, how much is the co-pay, how many days of something? But in general they all cover the same kind of mechanical operations; is that fair?

Mr. VLADECK. I think the coverage will be the same from policy to policy, yes.

Chairman STARK. I have heard it stated that to bring the Medicare beneficiaries up to the level of the President's proposed benefits would be fiscally irresponsible, I think was the word I heard by one distinguished member of the White House staff, but I want to think about that for a minute because it creates some problems.

I know you won't believe it, I am not 65 yet but when I get there, if I am in Blue Cross, I can't think why I would go into Medicare when I can stay in the same plan and Uncle Sam, you, HCFA, have to take out of the trust fund my premium. I suspect that my premium then to Blue Cross, the Federal portion of what I pay each month, is going to be more than you are going to charge me for Medicare. So there is a real incentive for me not to go into Medicare when I turn 65.

You can extrapolate that, if we lose all the new members in Medicare, particularly if you drain out of the trust funds a monthly capitation payment, you are going to run the trust fund down, and those who are on Medicare will be stuck with a lot of older, sicker members, and we have lost the revenue. So it is a formula by the back door to destroy Medicare.

You can say, all right, you do one of two things. You can lower the benefits to the public, which we may have to do to save money, or raise the benefits; and I said, why is that so costly? If you take this—and I know these numbers are not decided, but let's assume the numbers are there and you take $4,000 a head for Medicare, $120 billion for 30 million people, and your original estimate was somewhere in the neighborhood of $1,500 a year for an individual, then the President's benefit for the under-65, if you crank that out to 235 million people and add it together, you only kick the average premium up to $1,700 for everybody, about 12 percent—increased by 12 percent of the people.

So if you think about it, maybe it wouldn't be such a bad idea to leave that benefit out and then the adverse selection that might come later in the first 5 years or so, if the Medicare system would be done away with—and as the competition wants to say, we would be competing Medicare against alliance programs on a real even playing field and not have to pass on to our colleagues, who will replace us when term limits go into effect, with a new notch which we are all sick of hearing about already.

Could that be accomplished without destroying the President's plan?

Mr. VLADECK. Let me——

Chairman STARK. Could we average out the premium if we had the money? Is there any reason that we couldn't?

Mr. VLADECK. Let me try to answer your question in several pieces. Let me start by talking about the benefit.

If you do a side-by-side comparison between Medicare with the drug benefit added——

Chairman STARK. Let's leave the drug benefit out.

Mr. VLADECK. I think it is important to leave it in because it is a major component of the difference between the comprehensive benefit package——

Chairman STARK. It doesn't amount to that much money, so for purposes of the calculation, let's just take acute care and leave pharmaceutical aside.

Mr. VLADECK. Leaving pharmaceuticals aside on both sides of the equation, the major difference between the basic benefit package for the non-Medicare population under this plan and the Medicare benefit package is the absence of a ceiling on out-of-pocket expenditures for Medicare benefits. The overwhelming number of Medicare beneficiaries who have very high uncovered expenditures at the current time have them as a result either of long-term care expenses or very high prescription drug expenses. So that——

Chairman STARK. They are paying for that.

Mr. VLADECK. So that once you add a prescription drug benefit under Medicare and a long-term care benefit for the disabled, the benefit packages, while still different for most folks, are not that radically different.

Chairman STARK. You are paying my supplemental gap coverage under 65 under the plan, but not my mother's. She is old, but she is not dumb. She is going to say, "Wait a minute, you are getting your medigap paid for," but her medigap may go up some because you are going to cut payments to providers under your savings.

I am just saying, if it is a couple hundred dollars per person, is it not possible to solve the problem mathematically if we are not going to cut Medicare benefits. So it means probably either reducing the benefits the President has suggested by increasing the copay or deductible or raising Medicare benefits by capping it, say, with a $2,500-out-of-pocket cap, which I recall somebody trying years back, or some combination, so they are about even. So we take that notch out of there.

Other than the numbers and the dollars, is there any structural reason in the President's plan that we couldn't do that?

Mr. VLADECK. I don't know of any structural reason why we couldn't. I can't give you an answer, I don't know the answer——

Chairman STARK. It was told to me that the only reason it wasn't in is because we don't have the money. Maybe we have the money.

Ms. FEDER. I just wanted to clarify: Rather than, will we have the money, I think the issue is the choice of mechanisms for financing; and so I would just extend the discussion to that, will we want——

Chairman STARK. That is a sort of separate side of the ledger. I am just saying there are some problems in the public perception

of this plan because the benefits drop when you hit 65; and for a couple of reasons, one the—I hate the word, but the "viability" of the Medicare program is questioned, and we will get to that later, how many people you think will drop out?

It seems to me that problem could get solved in a mathematical sense rather than——

Mr. VLADECK. I can't see a conceptual difficulty in equating the two benefit packages, but I also don't know what it would cost.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Welcome. I generally support the President's approach for cost savings and health care, but let me raise some questions as to the different roles that apply for Medicare and the alliances.

You mentioned in your oral presentation and in your written statement trying to avoid cost shifting.

I have difficulty understanding how we avoid cost shifting when we use a different standard for achieving the cost savings in Medicare than we do in the alliances. The alliances are going to depend upon some form of State initiatives or managed competition or some form of market forces, whereas in Medicare we still use primarily the rate system to achieve the type of savings that are in the President's proposal.

If I had my choice, I would fold Medicare into the alliances—I understand there are some political considerations in that choice—and then you wouldn't have the problems that Mr. Stark raised if everybody was in the same system with the same benefits under the same rules. It seems to me that would be the best way to handle it.

If we are confident we will get the same care through the alliances, why shouldn't Medicare be in the system?

Let me try the reverse of that. If we are confident that Medicare can survive as a separate program in a cost-effective manner, achieving the same types of cost savings as we can in the privately ensured marketplace, why not allow companies to buy, into Medicare as an option and open up competition between Medicare and the alliances?

Mr. VLADECK. On that particular issue, I think the reason not to permit people to buy or employers to buy into Medicare at this point, continues to be the lack of sophistication—particularly for the nonelderly population—in some of our risk adjustment measures.

Mr. CARDIN. We would have the same problem in the alliances, wouldn't we? If the Medicare buy-in played according to the same rule as the alliances, why not try to——

Mr. VLADECK. I think we know somewhat more about how to do some of the risk adjustment we need to do for the Medicare population than for the nonMedicare population because we have been worrying about it in terms of the Medicare HMO program for so many years, although there is still a lot we don't know.

The risk of having folks buy into Medicare selectively and of unloading particularly high risks on the public trust funds, while the better risks stayed in the private sector, seems to me to be very real.

Mr. CARDIN. The same risk, though, occurs under the alliances that high-risk people may try to buy into a particular plan. Don't we have to do risk adjustment among the different plans?

Mr. VLADECK. We do. It is less of a problem, I think, in the alliances because of the uniform rates folks will be paying, and the expectations about the way in which marketing and consumer choice will take place under the alliances. So, the major task of the alliances is to try to set rules that limit the ability of plans to, for example, market only in selective parts of a region and things of that sort.

I think there are still issues in terms of our ability to compensate for the risk in the alliances, which is why it is so important we do so much work on that over the next several years. It may be that in the private sector we will be on a path in which we will be reducing risk selection so dramatically that we can talk about a path on which we are making considerable progress. We are very nervous, from a public-expenditure/public-budgeting point of view, about creating more selections in which Medicare can be selected against.

Mr. CARDIN. How about putting Medicare into the alliances, totally?

Mr. VLADECK. I think the plan contemplates essentially a process under which the new system is fully up and running. To the extent that it is working very successfully for the non-Medicare population, we have the mechanisms in place to integrate the Medicare population into that system on a State-by-State basis, on the presumption that this will be a system that varies dramatically from one State to the other.

So we can say to current and future beneficiaries, we are committed, as our fiduciary responsibility, to protecting you and your interests relative to this system. We are not at this point going to move your Medicare system with which, by and large, you are now relatively satisfied, with which you are very familiar, into an unknown system until we are quite confident in a number of very specific, statutory ways that that new system will serve you at least as well as the current system serves you.

That is what the proposal calls for.

Mr. CARDIN. Thank you.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. Dr. Vladeck, it is good to have you here. It is good to have somebody with an education background, but who also has been in the trenches.

I have one question raised by Congressman Cardin that I would like to clarify before I go on. I would like to know when you assume the plan will be fully up and running? What date do you have in your mind when you say that?

Mr. VLADECK. Obviously, it will be somewhat different in different States, but we would expect that after a State establishes the alliances and adopts uniform universal coverage, there will be a period of 2 or 3 years for the development and implementation of its budget mechanism and its limitations on expenditure growth.

It would have to be after that system has been in place for some period of time before one could fairly evaluate the appropriateness of integrating Medicare.

Mr. McDERMOTT. Say we pass the bill next summer and the legislatures do it in 1995. You are talking up, full and running, by perhaps 1998, 1999?

Mr. VLADECK. Except for the States that will be first in the queue to put systems in place because they are already well along.

Mr. McDERMOTT. When you are talking up and running, you are talking about all 50 States up and working?

Mr. VLADECK. No, no. This would be State by State.

Mr. McDERMOTT. Let me move on to cost containment.

What are your assumptions about the percentage of the population that will join HMO's of whatever type as compared to those people who stay in fee-for-service? When they put this financing package together, what kinds of assumptions were made?

Mr. VLADECK. If I am not mistaken, the cost-savings assumptions—and this is somewhat secondhand—actually do not include a significant number for the movement of people from higher-priced to lower-priced plans. If I understand the modeling—and I am not the expert on this; I am a qualitative social scientist—but I understand that they built no savings assumptions into the model for the dynamic of people moving from higher-priced to lower-priced plans.

The major savings assumptions were related to, again, the initial savings from administrative simplification, from reduction of the overhead costs from the small, group market, secondarily from creation of a more disciplined environment for providers and provider payment, and third for the reduction in some of the costs that are now occasioned by inadequate coverage such as high use of emergency rooms.

Mr. McDERMOTT. If I understand what you just said, there is no assumption that people will move from fee-for-service to HMO's and, therefore, there will be some savings?

Mr. VLADECK. There is an assumption that this will happen, but it is not being relied upon for the projected savings in the model that we have been using. We believe that this will happen, but we also believe it is very hard to score.

Mr. McDERMOTT. Is that like a peace dividend?

Mr. VLADECK. That is why we are not putting a dollar figure down for it. We believe it will happen, but we wouldn't try to score it, so it is not in the assumptions.

Mr. McDERMOTT. The subsidization process that you envision in this proposal of low- and moderate-income individuals and businesses puts the government in a position of subsidizing private insurance companies because as you subsidize somebody who is paying a premium to a private insurance company, you are therefore indirectly subsidizing a private insurance company.

Wouldn't it be cheaper just simply to go to the government and let them provide the insurance and get out of the position of subsidizing some major insurance company's marketing program? Because all the large insurance companies will be marketing heavily to get people in, and that is going to be a cost built into the cost of that premium.

Why should we pay for that subsidy? Wouldn't it be cheaper to do it from the government level?

Mr. VLADECK. Let me say two things in response. One is, we think that the kind of economic signals that are being sent by the

limits on increases in premiums will leave in the market only those private insurance companies that are either relatively efficient or that have better mousetraps. We will not be subsidizing an open-ended laying out of public funds for private insurers.

The second issue is a judgment, both a political and a policy judgment, that the President and the rest of the administration feels that the public does not want to get to universal health insurance in the United States through an entirely public system. It is very hard at the boundaries or at the notches not to have a significant explanation of public coverage without having that boundary or that notch be very much a moving phenomenon.

Mr. McDERMOTT. So the public will be forced to pay for private insurance companies, whatever incremental cost there is, because they have rejected the idea of having it done in the public? That is the assumption you made?

Mr. VLADECK. I am not sure we are paying the companies. We are paying for the benefits of the individuals under a set of terms and conditions that will permit the insurers or whoever else administers the plans only the most limited kind of growth in funds. So, they will have to meet relatively high performance standards in order to stay in the game.

Mr. McDERMOTT. Thank you.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Mr. Vladeck, let me turn to page 3 of your statement. I would like to ask a relatively basic question.

You indicate in the second paragraph, "Employers will contribute to the purchase of health care coverage for their employees by paying at least 80 percent of the weighted average premium for health insurance coverage in a regional alliance or corporate alliance."

How will that work?

Mr. VLADECK. The way we envision this working is that in any given area there will be a number of plans which will have one of three sets of cost-sharing arrangements, but which may have different provider network and other attributes. Each plan will have a different premium. The weighted average premium is an expectation about relative enrollments in each plan, multiplied by the premium for each, divided by the total number of people in the alliance.

Mr. KLECZKA. So in alliance, with four or more plans, let's say that plan A is just a basic plan, and plan B is somewhat more than a basic with dental. Plan 4 would be the fee-for-service, which I envision to be the highest-cost plan.

You are not talking about averaging the four?

Mr. VLADECK. Yes, but we are talking about premiums only for the standard benefit package, so that there will be separate pricing and, in fact, separate insurance policies for those services that aren't part of the basic benefit package.

One of the ways in which you give consumers real choices is to ensure that they are purchasing a standardized product——

Mr. KLECZKA. A weighted average premium will be based on the basic plan?

Mr. VLADECK. That is correct.

Mr. KLECZKA. If you want a higher version, the employer still only pays 80 percent of the basic within that plan and the add-ons

will be like a supplemental plan? You will pay 20 plus your chiro, if that is not in, and your dental and whatever else?

Mr. VLADECK. I think the issue is, on supplemental benefits, there is no obligation on the part of either the employer or employee to do anything.

Mr. KLECZKA. Take, for example Plan B, which is a step above the basic. The employer would pay 80 percent of the basic in Plan B, but I would be liable for the additional? You keep shaking your head. How am I wrong here?

Ms. FEDER. Bruce is answering correctly. What we are saying is that essentially there is a guaranteed package of benefits that every plan must offer, and the employer contribution requirement is tied to the average premium for that benefit package.

Mr. KLECZKA. Which would be based on the basic benefit package?

Ms. FEDER. It is a guaranteed package which we think is quite comprehensive. That is what the employer contribution is tied to.

Mr. VLADECK. One more thing—we expect the differences in plans and in the prices of plans will come primarily from two places. One is, some plans will use more expensive providers than others; and second, some plans will have more limitations, will be closer to closed panels, and other plans will be mixtures of closed and open panels, and some will be purely open panels.

Those will be the two major reasons why the prices of plans will differ.

Mr. KLECZKA. We will talk about the per-capita baseline in another round. I will turn to the corporate assessment.

We are talking a 1 percent corporate assessment?

Mr. VLADECK. Right.

Mr. KLECZKA. It doesn't help not to have the bill.

Ms. FEDER. We have talked about an assessment at that level, but it has not been finalized.

Mr. KLECZKA. Assume it is 1 percent. Would this be for the corporations who are in the regional alliances as well as corporate alliance.

Mr. VLADECK. Only for the corporate alliances.

Mr. KLECZKA. There would not be a separate assessment for the corporations in the regional alliances?

Ms. FEDER. That is what is laid out, yes.

Mr. KLECZKA. So we have to worry about whether or not it is above the cap. Do the caps apply to the corporate alliances?

Ms. FEDER. No. The caps apply only in the regional alliances. When we are talking about firms who are forming their own alliances, the corporate alliances, they are not--

Mr. KLECZKA. Only the corporate alliances will pay x amount percent, which we are reading as 1 percent but could be more.

The last question, you talk about a tobacco tax. Has an amount of increase been decided upon? We keep hearing talk about extending that type of taxation, a health tax as you call it now, to alcohol and other items. What is the status of this issue?

Mr. VLADECK. My understanding is that no final decision on any of the specific financing items or the numbers associated with them will be final until the bill is introduced.

Mr. KLECZKA. So there is no set amount on tobacco at this point?

Mr. VLADECK. There are numbers being floated around, but there is no formal proposal as to the amount.

Mr. KLECZKA. And items like alcohol are still not off the table?

Ms. FEDER. I believe that we have been clear in terms of the revenue sources that we are looking to, and they relate to tobacco and the assessments.

Mr. KLECZKA. So alcohol would not be included?

Ms. FEDER. That is where we are now.

Mr. KLECZKA. So it is not off the table? We keep hedging; is it on or is it off?

Ms. FEDER. I understand that the revenue sources we have identified are the revenue sources we are looking to, and we are not looking to others at this point.

Mr. KLECZKA. So is it off the table?

Ms. FEDER. Yes, sir.

Mr. KLECZKA. Let me mark that down, along with the 100 employees of the National Health Board. I am making book on you; do you know that?

Chairman STARK. Mr. Levin.

Mr. LEVIN. I thought your answer was going to be, except for beer that comes from Wisconsin.

I guess you don't make the final decisions. You hesitate to say something is off the table.

Let me just ask you something more general, the issue of competition. There is—implicit in the questions here, there are some who are attacking the President's proposal for not having enough competition; and then there are some who are saying that the competition that will exist is really unnecessary—a kind of thin layer—and the best thing is to just eliminate it altogether, and we will save money by going to a single payer system.

You have lived with this, the two of you. If you would respond to it—the competitive forces that remain, how much and why they are important—how they will operate?

Mr. VLADECK. Let me just say a couple of words about that.

It is very clear that the market, as it now exists in health care, doesn't work very well and doesn't do what markets are supposed to do; and there are a lot of different explanations, and different people have different beliefs as to why that is. What we are trying to do in the President's proposal is to create a set of rules to permit competitive forces to have an impact not only, we think, on controlling costs but also on maximizing the choices available to consumers, without the illusion that we are somehow recreating a market of the sort that you would find in a textbook about certain kinds of markets.

We are seeking to recognize the difficulties in having market competition in the health care system and trying to ensure as competitive an environment as possible, because we know that under the right circumstances, such competition reduces cost, increases productivity and increases consumer choice.

I think we have been criticized because we are not creating a pure market for a variety of reasons. Perhaps most importantly, I believe that you can't protect consumers in a pure market. At the same time, we are continuing to rely on a largely private competitive system for doing this because we all feel, from the President

on down, that at the current point in our history there is good reason to have a lot of skepticism about the ability of governments to administer noncompetitive monopolistic sorts of systems. If we can create the right sort of competition within public programs, we can continue to serve the objectives of the public programs, while getting better results both for the beneficiaries and for the taxpayer.

So what we are proposing doesn't fit with anybody's pure theory. It is an effort on the part of government to establish a set of rules and processes that will produce the benefits of real marketplace competition while minimizing or reducing the risks that tend to happen in markets; and I think, for that reason, some of the folks who believe in markets above outcomes are unhappy with our proposal.

Mr. LEVIN. Could I suggest, as my 5 minutes expire, that you go to the next step. I think it would be a useful effort, and click off more specifically one, two, three, four, five, the ways that competition would impact.

Sometimes the defense of the President's proposal comes across as, well, the public won't accept going further, on the one hand, and on the other, it is real but we can't tell you exactly how.

I take it that embedded in the President's approach is a belief that there is more diversity, more pluralism, more different experiments going on, and I think it is important to outline that and to go beyond saying, well, another system would cause a shift to the tax sector, et cetera, et cetera.

So I think, in a word, your description is a useful, but there is a real need in a crisp, clear way to click off, here are five critical ways that competition would work, and you might add, would not work.

I think we were talking yesterday about who can bid or compete through an alliance, and this whole issue of the role of competition affects the answer. So competition has to be more than convenience or necessity in the President's plan, it seems to me.

So I would appreciate, if you wanted to do that, if you would put it down on paper and let me look at it.

Mr. VLADECK. We would be delighted to do that. I think you have hit right on point on what is a very important aspect of communicating accurately what the President's proposal seems to achieve. I think you have given us probably clues on at least three of the five items we are going to list in terms of pluralism and creativity and so forth. So if we can start by using something as our basis, we will turn those back to you as soon as we can.

[The information follows:]

COMPETITION UNDER THE HEALTH SECURITY ACT

Health plans, including fee-for-service, managed care, point-of-service, and others will continue to exist and compete for enrollment under the Health Security Act. Plans will have to provide a guaranteed benefits package and not discriminate against individuals or eliminate coverage of preexisting conditions. In order to compete, plans will have to provide better quality services, increased provider options, or lower costs.

Consumers will have improved knowledge to assist them in the selection of health plans. The market will be enhanced by a "quality report card" for each plan which will enable individuals to objectively examine the plans and their ability to meet those individuals' needs.

Universal coverage will eliminate cost shifting among various sectors of the population enabling plans to compete on a level playing field.

Community rating will ensure that individuals have equitable access to health care plans. Plans currently compete for enrollment of health people; individuals with pre-existing or terminal conditions will not be restricted from coverage. Alliances will improve the bargaining power of small business and individuals to purchase affordable health insurance. By spreading risk over a large group of people, alliance will be able to negotiate with insurers for the best prices.

Reasons market competition should be included in a health reform strategy:

1. Quality -- Competition will increase the quality standards for health care delivery. Health plans will be forced to deliver high quality services to maintain their enrollment because consumers will have the option of switching to another plan if they are not satisfied with their plan. Consumers will also be provided a report card on all health plans in their area containing information, including consumer satisfaction, to assist them in selecting the plan that meets their needs.

2. Cost containment -- Competition will be effective in holding down costs. With appropriate incentives for plans to compete on the basis of cost effectiveness and quality, we will see the cost of health care grow more manageably.

3. Flexibility -- Different factors drive cost and quality problems in different communities. Research shows that practice patterns (and the resulting cost and quality of care) vary enormously across the nation. Health plans must be able to work closely with their physicians, hospitals, and other providers to understand prevailing practice patterns and help those providers provide the highest quality of care most efficiently and effectively.

4. Choice -- Healthy competition among plans in a well managed market place is best suited to making the broadest possible range of choices available to people. One-size-fits-all is not a preferred approach to health reform. Health care is a personal service, and individual choice of both providers and health plans is important to Americans.

5. Innovation -- Competition on the basis of cost and quality will foster innovation and encourage its use in the most effective manner. Medical practice as well as methods for managing health care are advancing constantly. For example, use of automation, clinical data profiling, and other innovations can promote better understanding of what works in health care and can assist health plans and providers in providing the most effective services and reducing the cost of care.

Mr. LEVIN. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Bruce, you saved Medicare by evening out the benefits. Let's save the economy. Altman yesterday promised the country a trillion dollars a year by the end of this decade in new investment if we just pass the President's bill. I suspect that is really a trillion dollars less deficit, but I won't quibble; he is the economist, I am not, so he obviously knows.

To get in, however, we have an issue of cost containment. And I have been suggesting that there is a danger in having two different cost containment systems, one on the public side and one on the private side. I don't care which way, they are just an opportunity for gaining, or indeed a chance to exacerbate a difference in delivery of services, either in quantity, quality, or style.

Is that a fair—is that a reasonable concern?

Mr. VLADECK. Certainly it is a reasonable concern.

Chairman STARK. It suddenly dawned on me that maybe there aren't two systems. Let's toy with this a minute. Implicit in the President's plan is a proscribed fee structure for doctors, is that not correct?

Mr. VLADECK. Well——

Chairman STARK. For the fee for service, there is a fee schedule to be determined by some group, right?

Ms. FEDER. Negotiated in the alliance.

Chairman STARK. I don't care. It is a fee schedule. We negotiate Medicare now, do we not?

Ms. FEDER. Yes.

Chairman STARK. All right. So both sides have a negotiated fee structure for physicians.

Is there anything comparable to a DRG for hospitals in any part of the President's plan?

Mr. VLADECK. We would expect that the alliance-based fees for fee for service——

Chairman STARK. The what?

Mr. VLADECK. The fee schedule that the alliances would use would include all the services.

Chairman STARK. So for purposes of discussion here, can we stipulate that both cost control plans as part of the plan, whether the current Federal plan and some State plans with Medicare have a fee schedule for DRGs and physicians? That is correct, is that not?

Mr. VLADECK. That is right.

Chairman STARK. This other part is a little trickier but it is not very far away. The other part of the President's plan, I believe, is a premium cap or control; is that a fair assessment?

Mr. VLADECK. Yes.

Chairman STARK. Well, isn't that in effect what we do when we allow risk contractors to contract with Medicare? They don't set it the same way, with you in the end we establish a maximum amount, different areas, that we will pay on a capitated basis?

Mr. VLADECK. That is correct.

Chairman STARK. Is that really any different in the end result from what the President has when he is saying we will have—these are done per person and they vary from plan to plan, really there

is no difference there in the final analysis between the two plans. Are you not in agreement, Judy?

Ms. FEDER. In general that is a fair——

Chairman STARK. There is a major difference in how they are calculated, don't misunderstand me. I am just suggesting that really we already have a mechanism that could easily result in premium caps. We could say we are going to pay no more premium if we bid out, let's say, and we do it under HMOs.

So what we would come to at some point if we wanted to have uniformity, those of us who are concerned with it, conceivably we could have many different ways to control the fees. It would be hard to identify where fees were broadly out of line. In Maryland, we would see what the hospital fees are, and in Wisconsin they might be different. They might be set by HCFA, they might be set by an alliance, but possibly what we would say is there ought to be, across the entire medical delivery system, fees, both for hospitals, doctors, and I would add pharmaceuticals, and on the other side, some which are calculating the payment for risk contracts, whether those risk contracts have to be an insurance policy, any other kind of a plan, and then it would really be rather difficult to cost shift one to the other, particularly if we got those fees into uniformity. Is that——

Mr. VLADECK. There is some uniform relationship.

Chairman STARK. I am not sure the bill is drafted that way at this point, but it suddenly dawns on me we may be battling with HIAA, for instance, over a pyrrhic enemy, in that the real question is going to be how you get there. The issue I think the AMA has grudgingly said they—like the RBRVS, they just don't want us to set the index rate. We do for Medicare, but you could easily say, go ahead, docs, set it wherever you want as long as it doesn't go over the Medicare amount, and let them fuss with it State by State.

But would you agree with me that there is some symmetry between what we are doing now and what is proposed in the end result, as it applies to the providers? Not in the way it is calculated.

Mr. VLADECK. I would agree with you that there is symmetry in what might be called our terminology or our classification of what gets paid for and how we define what hospitals do——

Chairman STARK. But they are basically limited in every regard.

Mr. VLADECK. Every plan in the system, regardless of the type, has to come to some arrangement with providers as to what they are going to pay for each unit of service.

Chairman STARK. Under the President's plan, there is no service provided that doesn't have a limit on it except this. This is interesting. Except the fee-for-service provision to an IPA HMO, where the docs get as much as they can gouge out of a patient. We have no control over that, unfortunately, but that is an oversight, I think.

Basically both plans, the current Medicare structure, and the President's plan, limit fees, limit DRGs, and basically limit payments to plans. They call it premiums, we call it capitated rates. But I think that is——

Mr. VLADECK. I think there is one important difference between the capped premium and what we now pay under risk contracts. And I think it is an important difference. When we pay a risk con-

tractor x dollars per beneficiary per year, that is a fee, that is what we are paying them. And in fact if that is radically different from the costs in the community, that generates a whole other set of problems.

What we are talking about, as a capped premium under the proposal for other payers, is a ceiling price below which we expect most of the action to occur in terms of innovative——

Chairman STARK. Is there anything in the law today that would prohibit Kaiser Permanente—you should hold your breath until it happens—from paying less than the capitated rate under a risk contract? A risk contractor voluntarily taking less? No.

And I would suggest, although that is a point of argument, that they won't under the President's plan either. These premiums will become the floor in a New York minute. But that is a question——

Mr. VLADECK. I think that is an important practical distinction. I believe we have a number of risk contractors in Medicare at the moment with whom, had I the power to negotiate a price, we would get a better price.

Chairman STARK. You are going to have that power sooner than you think.

Mr. VLADECK. I wasn't requesting it; I was just making a hypothetical observation.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

We have great individual quality care, great facilities, highest medical technology in the world, yet the system is terribly flawed. And I congratulate the administration for coming forward with a proposal that really addresses the system problems that we have.

One of the real problems that we have in our current system is that it discriminates against providers who want to locate in poor neighborhoods or in neighborhoods where there is a large concentration of elderly, because of the way that we compensate for care. The proposal that you bring forward deals with uncompensated care directly by having universal coverage, and that is so important. It is a critical element in successfully completing health care reform.

But a second problem that we have in our current system is cost shifting, where it is difficult for facilities or providers to treat our elderly or have a large concentration of treating our elderly because of the cost shifting between privately insured and those that are on Medicare. The proposal that you have doesn't eliminate the cost shifting, as I understand it.

I have been in Congress where administrations have come forward with cost savings in Medicare that I have opposed, because I was convinced that it would not reduce health care costs but would just shift the cost from one segment to another, and not really accomplish what we want to do in health care.

What assurances can you give this committee, what assurances can you give the American people that we won't just continue that type of cost shifting, that we will achieve the savings in Medicare that you have spelled out in order to meet the national budget targets that you have put into practice, but we won't do what is necessary with the privately insured marketplace, just causing costs to

be shifted and then making it more difficult for the elderly to achieve the same access to quality care?

Mr. VLADECK. Let me say quite clearly, because it is something we have spent a fair amount of time on, that we are very concerned about this issue. We will propose to you formally, in the bill, additional changes in Medicare provider payments only in the context of a comprehensive reform strategy. We would be opposed to any further reductions in Medicare provider payments or reductions in the rate of increase of Medicare provider payments outside the context of comprehensive reform, which is going to place more stringent growth limitations on the private sector. And I think that is about as clearly as I can say that.

The mechanism to ensure that happens is still being considered, and we would very much like to work with you on it. But our concern is that additional savings in the rate of growth of Medicare outlays in provider payments should only be sought in the context of a reduction in growth in the private sector.

Mr. CARDIN. I appreciate that and I look forward to working with you as to specific provisions in the legislation that gives us the best chance of improving the situation on cost shifting.

One way in which we have been able to move forward in this area is, of course, through State initiatives such as the all-payor rate system in Maryland. I appreciate the statements that have been made that would permit a State to use an all-payor rate system that stops cost shifting. But let me tell you, it is very difficult for a State to move forward with an all-payor rate system if there is a different reimbursement philosophy nationally on Medicare versus the privately insured, because if Medicare is only paying 90 percent of the costs versus private insurance, it is difficult for a State to do an all-payor rate system and stay within the national performance standards.

So I want to compliment you for the flexibility that you are offering the States on dealing with cost shifting by allowing the States to use a rate-setting mechanism to try to achieve cost savings that include Medicare, but just caution that you also need to make sure that the overall rules that we are working with will achieve the type of goals that would limit any cost shifting.

Mr. VLADECK. Well, again, sir, I think your concern about that issue is a specific example of the general case of the need to impose, create, or find some limitations in the growth of the private sector, even more significant than those of Medicare.

Mr. CARDIN. Thank you.

Chairman STARK. Thank you.

Before I recognize Mr. Thomas, I had intended to for the record state that the Republican leadership had a meeting scheduled this morning on an issue that is before this committee, and Mrs. Johnson is currently on the Floor debating an amendment of hers to the unemployment compensation bill, and that I know that all of our Minority Members had intended to be here during this hearing and it has been difficult because of scheduling.

With that, I recognize Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

The specifics are, we are trying to find a way to fund NAFTA that is acceptable to a number of people, and that is just as dif-

ficult as a number of the issues in health care. I am trying to get up to speed in discussing with the staff where we are and the direction we have gone. Since I have no desire to raise any questions about the Maryland system or what is going on in Maryland either in the newspapers or in the structure, I will turn it back to you for a minute so I can get up to speed in terms of where we are and what has been asked.

Chairman STARK. Without objection, I will recognize Mr. McDermott.

Mr. MCDERMOTT. Let me come back again, because you have been in the trenches, so I want to explore your view of time lines again.

Regarding the disproportionate share payments, at what point do you expect to realize any savings from DISH payments? How will you know when a State no longer has any uncompensated care and therefore you can pull out the DISH payments? Or are you going to do it gradually?

Mr. VLADECK. I think, in principle, most of what DSH payments are supposed to pay for should be eliminated with the advent of universal coverage in any State.

Mr. MCDERMOTT. So that is 5 or 6 years out. You are talking about 1998 or 1999. Then you would begin to realize the savings?

Mr. VLADECK. No, I think as the plan now contemplates, on day one, on January 1 of the year in which a State fully implements a system of alliances, the employer mandate will take effect, and the subsidization of the unemployed and part-time workers, and people with low incomes will take effect. So at a very early point in that year, everyone in that State should be covered and the problem of uncompensated care should diminish very dramatically.

So, elimination of DSH payments should take place roughly in concert with implementation at the State level, by which we mean incorporation of everyone into the system of insurance coverage and insurance purchasing.

Mr. MCDERMOTT. So a State Ways and Means chairman or a Health subcommittee chairman ought to be thinking that as soon as he picks up and passes this bill in implementing it at the state level, he loses his disproportionate share payment from the government at that point?

Mr. VLADECK. He loses some fraction of it, yes.

Mr. MCDERMOTT. Some fraction?

Mr. VLADECK. We are still working on it. We don't believe all disproportionate share payments in either the Medicare or Medicaid program ought to be eliminated.

There is still some justification for disproportionate share payments even under universal coverage for at least two reasons. First, it is more expensive in some demonstrable ways to provide services in low-income communities than it is in other communities. And while disproportionate share may no longer be the ideal terminology with which to characterize that problem, we are concerned that institutions serving those populations might not be adequately compensated for those expenses in the new system without some earmarked additional payment.

Second, we have made a commitment to continue to use Federal subsidies for institutions serving a large number of undocumented

persons, which in some States, is what some share of DSH payments are now supporting.

Mr. MCDERMOTT. Explain that mechanism. I have not seen that in the plan drawn out carefully enough for me to understand how you are going to deal with those States who document undocumented workers.

Mr. VLADECK. We are not talking about insurance coverage for undocumented persons. We are talking about identifying those communities and particularly those providers which can demonstrate are serving lots of those folks and targeting some very specific subsidies to those providers for services. And we intend to use some of the funds now flowing to providers through Medicaid DSH payments, to serve that purpose in the new system.

Mr. MCDERMOTT. So some people will lose their DISH payments and other people won't lose their DISH payments depending on whether they can prove to you that they are serving large numbers of people without insurance cards?

Mr. VLADECK. Some part of the DSH payments.

Mr. MCDERMOTT. Some parts. OK.

Well, let me move to another question, because we have several former Ways and Means Chairmen on this committee, and we always think what it was like at the State legislature when we created a program. And you know the one income subsidy program we already have in this country—it is called welfare. And in the health plan you will have all the bureaucracy of setting up that kind of subsidy system, including judging who is eligible and who is not.

If my calculations are correct, there are about 50 million people in this country who are under 150 percent of poverty. Twenty-eight million of them are covered under Medicaid. So there are 22 million people not covered presently.

Give me your vision of the structure by which you will make a month-by-month determination as to whether somebody is eligible for a subsidy to pay their monthly premium. How would that work? Would you use the existing welfare system, keep the Medicaid system, or create a new one?

Mr. VLADECK. I am not sure "vision" is the word I would use, but the plan as it is now evolving—and we are still working on some of the details—envisions the following: for those folks who are eligible for income maintenance assistance, whether it is AFDC or SSI, those programs will remain in effect, and those income determinations will serve for purposes of determination of support for health insurance.

Mr. MCDERMOTT. One more form in the welfare office for those people to fill out?

Mr. VLADECK. I am not sure you need an additional form. You just need a mechanism to get the computer tapes—the monthly summary tapes from those systems—linked electronically to the computers and the alliances.

Mr. MCDERMOTT. So that is one——

Mr. VLADECK. That is a considerable portion of those folks.

Mr. MCDERMOTT. The 22 million others——

Mr. VLADECK. For the others, we are envisioning a system that is based on annual income, that is not tied to month-by-month de-

terminations, and that is largely based on self-reporting, subject to retrospective audit and reconciliation.

So that, an individual whose income is at 125 percent of poverty would go to the alliance and say, I need help with paying my share of the premium. The alliance would ask them to fill out a relatively simple form and tell the individual, "We are going to audit you at the end of the year based on your IRS data to see if you were telling us the truth. If you significantly underreported what your income was going to be, we are going to recoup money from you. If you have overestimated your income, we will pay you back something."

Mr. MCDERMOTT. Let us assume that I am a Boeing worker and I worked from the 1st of the year to July 1 and I made $24,100, and then I am laid off. Now, I'm responsible still to pay my 20 percent of my premium, and I don't know where the 80 percent comes from, but I still have to put my 20 percent up there.

Now, I go in and say, "I haven't got any money. I just got my unemployment check. I am only getting $680 a month and I can't afford my 20 percent." At that point I get my subsidy, and at the end of the year when they average it out, it turns out I am above 150 percent of poverty. I am then responsible to pay them back somehow for all the subsidy I got during the year. I will be dunned in my income tax at that point.

Mr. VLADECK. I believe that is correct.

Ms. FEDER. It is the job of the alliance to collect. It is not an IRS function.

Mr. MCDERMOTT. The IRS is going to become——

Ms. FEDER. I said is not.

Mr. MCDERMOTT. The IRS will not become tax collectors?

Ms. FEDER. Essentially it is the job of the alliance to collect from you. It is not dunned through the tax system.

Mr. MCDERMOTT. Through what mechanism? Will they dun your wages?

Let's say I am rehired on January 1 and I now owe the subsidy of $600, $700. How does the alliance recoup this sum from me?

Ms. FEDER. It is the job of the alliance to develop a collection mechanism working with the State, and the police powers of the State are available to the alliance.

Mr. VLADECK. It is a civil debt transaction, equivalent to a commercial debt.

Mr. MCDERMOTT. So it would be a garnishment of wages, basically?

Mr. VLADECK. That is the end of that process, that is right.

Mr. MCDERMOTT. Most people, if they have been unemployed for 6 months, won't have any other way to pay it; they will have to have it taken out of their wages over the course of the next year?

Mr. VLADECK. That is what I would expect would happen under those circumstances.

Mr. CARDIN. Would the gentleman yield?

I assume the alliance would have the ability to work out a payment schedule. They would try to work with the person who owes money to make it the most cost-effective way to recover the dollars involved. In most collection cases, the person who is owed money

tries to work out a way of getting payment. And the alliance would have that flexibility?

Ms. FEDER. Absolutely.

Mr. VLADECK. It is exactly analogous.

Chairman STARK. I would like to recognize Mr. Thomas.

We expect to vote in 5 minutes, and we could perhaps work right through the vote.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Once again, I apologize for not being here at the beginning.

I passed out two sheets. One is a financial chart, and the other is an organizational chart. I can assure you this was an attempt not to make it look complicated, but to try to understand it. Once you begin to follow it, it isn't necessarily complicated. It is just that there is a lot of movement of money from various places.

The area I would like to draw your attention to, for a comment about where the money goes is in the lower right hand corner. You need to tell me if we are not understanding the 239-page outline, since we do not have the bill to work from. We think most of these other lines are pretty clear on where the money goes. I don't know where in your outline or in the dispute resolution procedure for finances is between the alliances, the health plans and the providers.

See those dotted arrows going straight down in the lower right hand corner? Obviously, there is going to have to be a payment structure, but we can't find one in the plan.

Can someone enlighten me where it is or how you envision the payment method time frame dispute resolution? Obviously there is going to be some argument between the alliance and the health plans, in the Clinton plan.

Mr. VLADECK. Let me answer those parts of the question that I can, if I may, and Judy can answer the other parts.

We expect that the contracts between the plans and the providers will be exactly analogous. In fact, they will be the same contracts that plans now have with providers.

Mr. THOMAS. That relationship would pretty well be moved over wholesale on the HMOs and the others.

Mr. VLADECK. The legal structure of the relationship between the alliances and the plans will largely be defined by the States, which have a number of very important responsibilities relative to the certification of plans, the assurance of solvency on the part of plans, and to maintenance of quality performance.

Mr. THOMAS. But all of those portions of a plan at the State structure are going to be approved by the national health board; it has the final say overall on the plan that the State presents.

Mr. VLADECK. That is correct.

Mr. THOMAS. And I can't envision a degree of universal commonality among all of the plans in those areas. There is going to be a lot of diversity.

Mr. VLADECK. We hope so.

Mr. THOMAS. And I guess it is a dynamic that you have to see in action to determine because you don't know what it looks like because you haven't seen it.

Can you give me some feeling for discussions about payment arrangements and payment dispute resolution mechanisms that you envisioned? Are there models out there that would be similar to the provider health plan structure that you would envision as a boilerplate that you could pick up and have between the alliances and the health plans?

Mr. VLADECK. I am sitting here trying to think of analogies, and——

Mr. THOMAS. We don't have to belabor it. I couldn't find anything in there. I would just like to hear some thinking, because obviously folks have talked about it.

Mr. VLADECK. Indeed, I know that one of the issues in trying to complete drafting of the bill, to some degree, is trying to figure out the extent to which standards or criteria, what should be in the State plans, should be included.

Mr. THOMAS. I guess my statement is, if you haven't done it, don't do it, because we won't see the bill until next year if you are going to go into it.

Ms. FEDER. We guarantee it sooner than that.

Mr. THOMAS. This chart lays out what decisions have been made. Over here where we have created the box corporate alliances and run them up to the Department of Labor, which is the structure that you have, I was struck during, I believe it was the first day of testimony from Dr. O'Keefe, of the Washington Business Group on Health, representing a lot of Fortune 500 type companies, in response to somebody else's question, in your judgment, how many of these Fortune 500 type companies would not go separate on a corporate alliance. They would in fact be plugged in under the regular structure, and if it is surprising to you, what do you do with the 1 percent of the money you were going to use in the structure to fund various things if it isn't going to be there because it is in the structure? Has that been discussed?

Since the 1 percent was added late, and I was surprised that people wouldn't go on their own if they are above 5,000, there was no hesitating. She said, in my preliminary discussions, they all say they are going into the regular structure.

Ms. FEDER. We discussed that to some extent yesterday, and I think that first of all there are many people who are viewing the provisions of the plan and weighing their decisions, and it remains to be seen. But as Bruce indicated, the 1 percent assessment has to do with obtaining resources from those who would be outside that others are paying by virtue of their participation in the regional alliance.

Mr. THOMAS. So you believe it would essentially be a wash. If they come in, they will be paying through the regional alliance, and this wasn't found money or added money that was needed to balance the books?

Ms. FEDER. No, actually we have discussed that assessment from the beginning throughout the process. I think the question is, how was—the issue was how to collect it, whether to collect it, and so on.

And I also would say that we will look at and continue to look at the overall financing structure based on participation. So I think

it is an important issue. But I believe this particular one is addressed.

Mr. THOMAS. And you felt comfortable that the 1 percent was appropriate.

Is there any need to reevaluate or adjust if that pool of 1 percent payers is smaller than would normally be anticipated, or that it was a kind of an arithmetical relationship but not any kind of geometrical. If it goes down, since they are in the alliance and they pay the proportion, if they are out, they are out?

Mr. VLADECK. Obligations of plans in a regional alliance don't apply to the corporate alliance. You don't want to create an incentive to stay out because they get to save on a community expense that should be self-correcting. But it does raise the question as to whether 1 percent is the right number. That is one of the reasons we are looking at the number.

Mr. THOMAS. Thank you, Mr. Chairman.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. We just had the first bell, Mr. Chairman, so we will go vote shortly. I would like to get this question in and hopefully the answer in before I have to leave.

On page 11, you talk about the program for early retirees, those who take early retirement age 55 to 65, wherein the Federal Government will pay—the taxpayers, that is, will pay 80 percent of the health care costs—and the employee will pay 20 percent, unless there is a previous agreement with the employer, in which case the employer could pay the 20 percent.

Now, my problem with this section is that I believe the two things a retiree looks at, the normal or early retiree, is whether or not the income will be sufficient in retirement years, and very close thereafter, whether or not health benefits are going to be provided.

Now, let me give you an example of a retiree. Corporate executive, decent golden parachute, retirement income $50,000 a year, takes early retirement at age 55 to do a little fishing and a lot of golfing. That person under this proposal will have his health care plan paid for by the taxpayers to the tune of 80 percent.

Now, could you give me the rationale for that type of public policy, and indicate to me the fairness in that for the taxpayers who are still working and struggling to pay not only their 20 percent but 80 percent for the guy who is on the golf course?

Mr. VLADECK. Let me start on the answer, but Judy may want to add to that. The retiree you described is far from the typical retiree.

Mr. KLECZKA. It is going to happen. There is no provision. Let's use my example.

Mr. VLADECK. And our concern is the increasing number of people who are retiring because that is the only option to being laid off or to losing their jobs or are being provided incentives to move into early retirement, who can't get health insurance——

Mr. KLECZKA. Answer my question, and if you want to ask me a question I will answer yours, but use my scenario in your response.

Mr. VLADECK. The answer is that it is very hard to provide help for the majority of retirees between 55 and 64 who can't now get

health insurance, who can't afford it themselves without in some way helping the person you described as well.

And we are working on refining the proposal to increase the equity of the effects in terms of who is eligible for that assistance, which employers are eligible and which employees are eligible.

Mr. KLECZKA. In the documents we have thus far there is no income-based structure for the 80 percent.

Ms. FEDER. I believe in that document. We indicated that there may well be a maximum income to be eligible for the 80 percent, and we continue to address precisely the problem that you are raising. And so I believe that there will be a ceiling in our legislative proposal, and we would like very much to continue to work with you to achieve that.

Mr. KLECZKA. I sure hope so. What I think this policy will induce is a lot of early retirements, above and beyond the situation where the employee is going to be laid off anyway, so you are going to see I think gigantic growth in this segment of the health plan.

In fact, if my information is correct, you have already reestimated the cost of this provision from some $4 billion to $6 billion, and Judy can correct me if I am wrong there.

Ms. FEDER. I would just clarify that essentially we are looking at a range of 4.5 to 6. And one of the things that frustrates you—I know it frustrates us that there are variations in the numbers—is that we continue to refine the estimates as well as rely on multiple estimators.

Mr. KLECZKA. What frustrates me more is the actual policy involved here, because I happen to think for an early retirement situation not only does the early retiree gain but also the major gain goes to the employer. He or she will either hire an employee at a lower wage so there is a savings to the corporation, or if it is an attrition-type thing, that employee's slot will remain vacant so there is a larger savings.

Why not have a phaseout for employer contribution at age 55, 80 percent, at age 56, 70 percent, etc? Because I think to let the employer be held totally harmless in the situation is very unfair to the taxpayers. Then you will have a situation where if I take early retirement at age 55, I get my 80/20, me paying the 20, to age 65, then I go on Medicare, then I have to pay 25 percent, which is the current arrangement, unless you envision that being changed also.

Mr. VLADECK. I believe all of those concerns, which are very real, are one of the reasons that we are still in the process of trying to formulate the precise policy in this regard.

Mr. KLECZKA. This is the budget-buster. If any provision of the bill is going to blow out the window, this is the one that is going to do it.

Ms. FEDER. Congressman, the concern that you raise here also with respect to encouraging early retirement is one that we have given and continue to give a great deal of attention to, and in the draft plan we note that we have under consideration assessments on corporations who do currently have——

Mr. KLECZKA. I just read that in The Wall Street Journal, for a three-year period. But that is still a meager contribution. I think it comes up to about 50 percent.

Ms. FEDER. As I indicated yesterday, I would rather discuss the specifics of that with you. But the fact is that we have both included estimates of the likely inducement of early retirement mechanisms to address the funding in such cases, and so we would continue to work with you on refining that policy.

Mr. KLECZKA. That might be true, Judy, but the problem is every weekend we go home we are being asked questions about this. In another 2 weeks I am going to have a health care forum. The only thing can I talk about is the items and the discussion that you provided us and the basic format of the plan. These are the questions that are being asked us from our constituents and employers, both large and small.

So we are really at a disadvantage. If I am going to have a working knowledge of this and other sections, I have to know where you folks are. I hope the questioning doesn't seem hostile, it is just that these are the very same questions we are getting back home, and if we are going to hopefully do something to health care reform and hopefully sell it to a populace which is not too keen at this point, I think we are going to need some specific answers.

Ms. FEDER. I appreciate your concerns, Congressman. I think they are legitimate. I think that we share those concerns, and we will continue to do our best to assist you in working with constituents.

Mr. KLECZKA. When the First Lady was here, I indicated three major problems with the bill as presented, not bill but the proposal, and one is the national health care board, one is this section for early retirement, and then one that we are all concerned about is the total cost, and to make sure that at the bottom line of the page, this thing balances. I don't see that happening today. But we will continue talking.

Thank you.

Ms. FEDER. You are welcome.

Mr. MCDERMOTT [presiding]. The Chairman has asked me to continue the hearing.

What is the total dollar figure that you assume will be collected as "premiums"?

Mr. VLADECK. I don't know—I am not quite sure I understand the question. What do you mean, to raise in premiums?

Mr. MCDERMOTT. How much will the alliances, nationwide, receive in premiums? What is the total costs that you expect employers and employees to pay in that?

Ms. FEDER. Congressman, we can provide you that figure. To give you one right this moment would be gambling.

We are looking at premium revenue, which is similar to premiums we already collect, plus additional premiums from those who are now not contributing, making the adjustments we expect.

Mr. MCDERMOTT. But making an estimate of whether you could finance this or not, you must have made some assumption about what the premium revenue would be nationwide.

Mr. VLADECK. We absolutely have—and again all these numbers, the specific numbers will be gone through in more detail, but what we have basically done is identify what we expect an average premium to be.

Mr. MCDERMOTT. Which is what? How much?

Mr. VLADECK. I think a number that has been talked about—and again, I think these are provisional numbers being refined and checked—is something on the order of $1,800 for an individual on average, and $4,200, or $4,400 for a family with children.

Mr. MCDERMOTT. That is for a family of four or just a family?

Mr. VLADECK. Again, the premium structure we are talking about is for a two-parent family with some number of children.

Mr. MCDERMOTT. And then the savings that you expect from this, what number are you putting on that? What do you think is a realistic number or what is assumed?

Mr. VLADECK. Perhaps I can talk about assumptions. Take this average premium cost, for everyone who is not now in Medicare or Medicaid, where we have good numbers on what we are spending, and multiply by the number of people you believe will be in those categories. You subtract out what is now in the private health insurance market. You figure out the number of people in the categories who will require subsidies and multiply those by the premium amounts. There is an additional cost for the provision of that subsidy.

You then can take the total premium outlay number and the Medicare and Medicaid numbers, use the OMB baselines, which are not far off from the CBO baselines as I anticipate them, for annual growth and outlays in each of those categories, and make some assumptions about where you want to set budget targets, which generate savings numbers, which provide some of the funds you need to pay for those subsidies. I hope that is all entirely clear.

If you have a spreadsheet in front of you, I think you can see it with much less complexity than I have described.

Mr. MCDERMOTT. There is no such——

Mr. VLADECK. There are many such spreadsheets. What we are trying to make sure of is that we have a spreadsheet that everyone with quantitative expertise in the administration agrees on in terms of the assumptions and the explanations. Within the very near future, when we sit down with you to go over it, we will all know exactly what we are talking about.

Mr. MCDERMOTT. You are saying then at this point there is no fixed budget that has been decided. You are still making adjustments in those numbers?

Mr. VLADECK. I am concerned by what you are saying about a fixed budget, because I guess, you know, we have been as guilty as anyone else in terms of the terminology, in terms of the semantics. There is not, as part of this process, a single health care budget for the United States of America, as it were. There is a set of estimates that are being refined with particular focus on what the impact of all these various aspects of the plan will be on a Federal budget.

There is also a set of estimates of what it will cost to provide the various subsidies associated with this plan. And there is a set of projections about savings on the private side as well as on the public side.

But again, and we have been guilty on the terminology, there isn't in all of these calculations a global health care budget for the United States.

Mr. MCDERMOTT. I am concerned about this. I assume that when they bring the bill up here, there will be, right behind it, a spreadsheet detailing how it works.

Mr. VLADECK. That is our expectation.

Mr. MCDERMOTT. I have done enough of this at the State level to know that if you are 1 percent off on the estimates, you are $8 billion off. If you are 2 percent off, you are $16- or $20 billion off nationally.

We don't know exactly where it will be spread. I think that is the real concern we have in listening to this. It sounds like it is still a moving target. What are the reasons for making it so difficult to pin it down?

Ms. FEDER. To say that it is a moving target, I would think is something of an exaggeration. We propose to put forward a draft plan in September, and have been working with you and with others in getting responses to that plan, as well as refining the estimates that we already had. And so in response, in order to make adjustments, some of the adjustments that I think are ones that you would like to see, it requires a reestimation and a reconsideration. And so I think that that is where the bulk of our time is going.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman STARK [presiding]. Bruce, back to Medicare, the plan calls for the development of a new sort of Medicare option, a point of service option.

It says that Medicare will contract for the creation of these preferred networks in major areas. I have a couple of questions here, so let me go all the way through.

One, who, or with whom, would Medicare contract to provide these point of service things?

And then, on the assumption that the providers would take a discount. Is that not correct?

Mr. VLADECK. Yes.

Chairman STARK. Why wouldn't we adjust that payment rate for all providers, is my second question.

And the third question is, what incentives would the beneficiaries be given to choose providers in the network, and then would that be part of the negotiations?

Mr. VLADECK. Let me answer all those questions but start one step back with the underlying logic of this notion, which is that for certain kinds of services, Medicare has a disproportionate share of the market, and——

Chairman STARK. Cataract surgery?

Mr. VLADECK. And cataracts, and there appears to be a very strong cost/volume/quality relationship.

Chairman STARK. OK, go ahead.

Mr. VLADECK. So we are already experimenting, as you know, with cataracts and coronary bypass surgeries.

Chairman STARK. Very popular with the ophthalmologists.

Mr. VLADECK. It may be increasingly feasible to do this. What we are envisioning is identifying a dozen or so services which account for a large volume of Medicare expenditures for a given population where we have that kind of market share——

Chairman STARK. You have to get all other services through this gizmo as well, wouldn't they?

Mr. VLADECK. You can then build your network in a number of different ways, depending on the particular community——

Chairman STARK. Are you envisioning something like this?

Let's say in an alliance there is one fee-for-service program. You don't care about it in the other programs because the contracts are done by the health plan. But that if in that fee-for-service program I opted for the low option, I might have to agree to take certain specific services, cataract surgery, orthopedic surgery, through a more limited provider group to get either some additional benefit that you would offer me a coffee mug or a T-shirt or something for signing up. Is that——

Mr. VLADECK. That is conceivable. That is not what we are anticipating or what we are contemplating.

Chairman STARK. It doesn't have to be a coffee mug.

Mr. VLADECK. We are contemplating being able to say to our beneficiaries, at least in big metropolitan areas, for the following services if you go to a preferred provider we will waive part or all of your coinsurance. You are entirely free to go to other providers under existing coinsurance arrangements." And we will then benefit by having——

Chairman STARK. A two-tier negotiated system for the docs?

Mr. VLADECK. We will have negotiated with those higher-volume providers to say that you will get more business, but we want a discount off what we would otherwise pay you.

Chairman STARK. I would mark that down as a brilliant piece of legislative opportunity. We could trade a lot for that one.

Mr. VLADECK. We believe this is a comprehensive package.

Chairman STARK. OK. You say that all managed care plans would be required to contract within 3 years. And further, the HMOs and alliances have to sign up as Medicare contractors, but if you stay in one, they don't.

Do you see what I am saying? If I am in an HMO and I turn 65, I can stay in it. But if I want to go into it and it hasn't qualified as a Medicare contractor, I can't. Is that just a glitch? For any reason?

Mr. VLADECK. No, I think that is an issue actually of some significance. Any Medicare beneficiary, right now, has the option to enroll in a HMO with whom Medicare has a contract. And we anticipate that, under reform, not only will every Medicare beneficiary still have that option but that the option will be extended to a lot more beneficiaries.

I think there are two different issues here. One issue is, does every beneficiary have the option to go into and then out of a HMO? The second is, does a beneficiary remain in the Alliance? And those are separate issues.

Chairman STARK. This is a discontinuity here. Kaiser in northern California does not now have a risk contract. If I were in it now and it were part of the local alliance, it could be part of the local alliance and not have a Medicare contract. But I could stay in it when I turn 65. Therefore, I could, as a Medicare beneficiary, stay in a plan that you did not have a contract with; but somebody else

who is over 65 could not get into the same plan I am in unless you had a contract.

Mr. VLADECK. That is one of the things we are trying to fix.

Ms. FEDER. I think, Mr. Chairman, that that is a transition issue, because we say that within 3 years all plans will have contracts.

Chairman STARK. In other words, within 3 years every plan and every alliance will have a Medicare contract, but at a different level of benefits?

Mr. VLADECK. That is correct.

Chairman STARK. I keep my paranoia, which my psychiatrist tells me may be real because people are out to get Medicare; that this is a design to do away with Medicare somewhere between 3 and 5 years.

Mr. VLADECK. I don't think we are talking about a different level of benefits. I think we are talking about a different level of supplemental premium for the same benefits.

Chairman STARK. To the seniors, where the only difference in benefits is the question of co-pay and premium—and they have to pay $100 a month to Prudential, God help them, for a supplement when you are giving them the supplement for free. If you don't think they are going to figure out that is a difference of level in benefits——

Mr. VLADECK. The only difference between that circumstance and now is that seniors only have those choices at the moment in those communities where we have contracts. If there are plans in every part of the country that are prepared to enter into those kinds of deals——

Chairman STARK. The assumption that somebody said when you give them extra benefits, that is, you said pharmaceuticals; let them pay for that, kick up their Part B premium. They still have an obligation. Many people say, well, most seniors have medigap. They do, but they are paying $100 a month.

To say that I can stay in a plan that doesn't require the supplemental payment is not a difference in benefit, it is to try and flimflam the old folks. I don't think that flies.

Ms. FEDER. Mr. Chairman, I want to make sure we are clear here. Whether the individual, the Medicare beneficiary, turns age 65 and stays in an alliance plan or whether they are over 65 and they join such a plan under a contract, Medicare is only paying for what it would otherwise have paid. It is only paying for the Medicare package, essentially. So that under either arrangement there is potentially a premium charged to the beneficiary.

Chairman STARK. Take the fee-for-service comparison where this doesn't wash. If I have your level of fee-for-service reimbursement, it is more generous than the current Medicare level of fee-for-service, and it could conceivably be at the same rates. But by staying in Medicare, I am disadvantaged at least to the tune of what I would have to pay for enough supplemental to bring me up to yours plus my Medicare premium.

There is a more generous benefit for under 65. You continue at that level and you stay in the plan.

Mr. VLADECK. But you have to pay the difference between what Medicare's outlay for you would be if you were in conventional

Medicare and what the cost of that plan would be in an alliance. If that plan can give you a better benefit package and lower co-payments for less than you would have to pay under Medicare, I would say more power to them, assuming we are protecting ourselves against risk selection, which is the worrisome part of this.

Chairman STARK. What you are telling me is, if I am in Blue Cross Low Option, and I am 64, the minute I turn 65 and wish to stay in that plan, I have to pay more out of pocket than I am currently paying?

Mr. VLADECK. Almost undoubtedly.

Chairman STARK. Then that is a decrease in my benefit; you are sticking it to me when I retire. You don't think I am going to think that is a decrease in my benefit?

It is the same problem my father-in-law, as a Teamster, is going to figure out. When you make him pay a couple more points, he is going to say, "You cut my benefits."

I didn't cut his benefits. I raised the amount he has to pay. The seniors are going to see that as a hit. I wish it were otherwise. That is why it is a little disingenuous to tell a senior—the loss of money is the loss of a benefit.

Mr. Cardin.

Mr. CARDIN. Isn't that the current situation?

Ms. FEDER. I think there was a misunderstanding. You are focusing on the shift from what you get as a younger person to what you get when it is Medicare; and the issue essentially is that in the current system, there are changes when you go from an employer policy to a Medicare system, and that is what I think you are addressing.

Chairman STARK. But——

Mr. CARDIN. I would be glad to yield to the chairman.

Chairman STARK. But you are paying for it. You are giving it to me free when I am 62, 63, 64 under your proposal; and you are charging me when I turn 65, and that may not necessarily be true now.

Mr. CARDIN. Reclaiming my time, I don't mean to answer for the administration, but if I understand the circumstances you just stated, we don't know what the current arrangements are, because each employer is a little bit different on how they handle your needs at the present time. Some employers are more generous than others on the share paid directly by the employer and some by the employee.

One thing that is clear is that subsidy under the Medicare program is a lot greater, so that it is difficult to make those types of comparisons in isolation. Is that what you wanted to say?

Ms. FEDER. Exactly.

Mr. CARDIN. Let me shift to the issue that I guess concerns me the most, and that is how this Federal system meshes with the State flexibility issues. You will have States that will want to go forward quicker than others.

You will be, at the same time, establishing a National Board. You have delegated to the National Board a lot of health care issues that cannot be resolved as we are passing the legislation. States will have to live with the policies that the National Board determines, yet they will want to come forward with plans, some

quicker than others, in order to take advantage of the fast-track approval and the resources that you are making available.

How does that all fit together? How do you reconcile the desire to establish national policy through a board, with the flexibility to the States to move quickly and to make decisions quickly to implement a system?

Ms. FEDER. You raised it in your outline, because essentially the fast-tracking is a recognition that the—there will be issues addressed through regulation that States could not accommodate if they wanted to move fast. So what we are trying to do is create a situation in which States, as long as they comply with the broad principles, the guarantees of the plan, will have flexibility to address, to design their systems as they see fit in advance of those regulations.

The concern, then, is that how would they adapt over time, and there is an expectation that there would be that adaptation over time.

Mr. CARDIN. So as a State moves forward, the Commission will come in with certain regulations or certain policy decisions that may not be totally consistent with what a State has done. You envision that the National Board, or that the Federal mechanism, would accommodate the actions previously taken by the States in good faith to move forward?

Ms. FEDER. There would be a time period over which accommodation would be reached. I think that that is the way we have thought about it thus far.

Mr. CARDIN. I appreciate that answer. I still have a difficulty that States that have put together good plans—and I am not just talking about Maryland, but States that have moved forward with different concepts that may depend upon different parts that are inconsistent with what you are trying to do with the different requirements at the national level, but they have achieved your objectives of universal coverage of costs that you want without discrimination, et cetera; yet because you are trying to give national guidance, it may not be exactly what that State has done.

Ms. FEDER. I think that there will be—in the legislation, I think some very clear principles about the models and what is expected under the Federal system, so that the broad parameters and the fundamental structural features, I think, will be very clear.

I think that it will be other aspects or specific design issues within those parameters that will be at issue.

So I think it will be less troublesome than what you put forward.

Mr. VLADECK. I think it may be less troublesome, as well, in another regard. In terms of States that are moving toward significant coverage expansions, we see their plans because it is hard for them to implement them without a Medicaid waiver; so we have been talking to Hawaii and Oregon and to other States.

As you look at what they contemplate doing and how they contemplate doing it, it is hard to see very significant potential conflict between the national policy that would come about. We may be talking about some modifications in the expected benefit package at the margins, some differences in the mechanics of the employer mandate—in defining who is a part-time employee—but again our

empirical experience suggests this should not be as great a problem in the abstract as it would appear to be.

Mr. CARDIN. But you don't envision that States will have to go through a waiver process?

Mr. VLADECK. No. I am just saying that we have been talking to some of the States that are most out front in this regard and, based on that experience, I wouldn't anticipate this fast-tracking being a big problem.

Mr. CARDIN. Thank you.

Mr. KLECZKA [presiding]. I have a couple of wrap-up questions. We talked about some type of an income cap for the early retirement benefits. What amount would that cap be set at?

Ms. FEDER. We are looking at that in the design of the overall policy, so I think it would be premature—I am sorry to say that to you——

Mr. KLECZKA. It is reported that there was a figure released of $100,000. Have you read that?

Ms. FEDER. That is one of the options under consideration.

Mr. KLECZKA. So anyone with $100,000 in income or what?

Ms. FEDER. That is correct.

Mr. KLECZKA. So anyone with $100,000 in income, age 55 to 65, would have to pay their own health insurance. Anyone with income of $90,000 you would have the taxpayers pay 80 percent?

Ms. FEDER. We are talking about glitches here, yes.

Mr. KLECZKA. On page 6 of your testimony, you talk about that the National Health Board will calculate a per capita premium target for each alliance and that there will be adjustments to that. At what point in time will that amount be made known to the alliances, because I assume there will be a ceiling?

Ms. FEDER. That is correct.

Mr. KLECZKA. At what point in time does the alliance know what the per capita amount is?

Mr. VLADECK. It will be made known to the alliances at least 120 days prior to the date on which the system goes into place and actually functions in their States. They can then conduct the kind of bidding process they need among the plans to set their first year's premiums.

Mr. KLECZKA. So the plans that will be bidding to the alliance will have knowledge of what that per capita is?

Mr. VLADECK. The theory is, at the moment, that the per capita amounts will not be public information but will be made available to the alliances, at least through the first round of bidding. We want as open a slate for the bidding process as possible.

Mr. KLECZKA. That might be true for their first go-around, but once that per capita is out there, in the next year, with open enrollment—I fear with that being established, whatever that amount is will become the floor and not the ceiling. How do you respond to that?

Mr. VLADECK. You are not alone in expressing that fear.

Mr. KLECZKA. My biggest fear was knowing at the git-go what it is, because everybody will come in with that being the absolute floor and then tinker on the edges.

Ms. FEDER. I think that there is a lot of feeling from the experience in States that are trying to build these kinds of systems in

the current market that there is a highly competitive process in the initial phase and that—as plans are competing for market share, that they will have every incentive to come in as low as they can. That is the thinking as to why the budget or the premium target is a safety net as opposed to a determinant of the premium.

Mr. VLADECK. The other piece of that, however, is that it is a very good safety net in the sense that even if it does become a floor with limitations on year-to-year increases, you are starting at a substantially lower level than you would have been without the system.

Mr. KLECZKA. The last concern is relative to title 19. We are attempting to merge that into a system where recipients will join a regional alliance like anyone else.

What happens in the case where a current benefit under title 19 is better than the one being proposed? I use the example of the drug benefit. Right now, I think there is a very small co-pay under the drug benefit, and the basic plan will be $250 out of pocket, maximum annual cap of $1,500.

What happens to that title 19 person with this change in, let's use the example, of the benefit?

Ms. FEDER. When you talk about the deductibles, that cost-sharing structure you put forward is what obtains in a fee-for-service plan. In a low cost-sharing plan like an HMO, that deductible is not present and there is much more modest cost-sharing, so it is much more in line with the benefits that low-income people have today.

Mr. KLECZKA. So you say, there will be plans on the market where even though that is the basic benefit, they will go to the low option and have no deductible?

Ms. FEDER. The benefits are the same; what differs is the cost-sharing. So what we are talking about is, a plan that offers that low cost-sharing is much closer to the benefit that you describe.

We have also said that if that plan is not available in an area where low-income beneficiaries live, then they are entitled to that same low cost-sharing in another plan.

Mr. KLECZKA. If they are not in the alliance, where do they go?

Ms. FEDER. In their particular area?

Mr. KLECZKA. Their area is their alliance.

Mr. VLADECK. Then there has to be an additional subsidy to cover the difference in co-payment.

Ms. FEDER. In other words, we are guaranteeing that low cost-sharing option to them?

Chairman STARK [presiding]. I want to go back to this disparity in benefits.

I certainly don't want to leave the impression that it is not going to cost them more to go into Medicare. I think it is fair to generalize that the administration's approximate benefit package is right around in the neighborhood of Blue Cross Low Option, and I believe——

Mr. VLADECK. I think that is fair. It is not the low option. It is the standard option.

Chairman STARK. What is the individual out-of-pocket cap?

Mr. VLADECK. $1,500, I think.

Chairman STARK. So if I am the average person working, the maximum, using numbers under the present proposal that I would have to pay to have a plan that would have—forget about whether I have co-pays or not and depending on whether I went into a HMO or stayed in fee-for-service—is $360 or 20 percent of the $1,800 if that figure holds. So my cost max in the President's plan is $30 a month and my risk is $1,500.

So if I have the $1,500 and earn 6 percent on that, I should take $90 off, but I won't complicate your lives with that.

If I turn 65, how will I pay differently from how I am paying in the President's plan? I am in this plan and I have this out-of-pocket cap and I have been paying $30 a month, what will I pay?

Mr. VLADECK. We don't know, but a lot more than $30.

Chairman STARK. Not only a lot more—I will pay the $30 premium for part B——

Mr. VLADECK. If you stay in Blue Cross, you will pay a lot more the day before you turn 65.

Chairman STARK. That is not what you said. I could continue in your outline, I could continue in my plan——

Mr. VLADECK. But not at the same premium level. I think that is what the policy——

Chairman STARK. You mean to tell me, you are not going to continue my——

Mr. VLADECK. The premium level, once you turn 65, in the alliance plan is a different premium level because the alliance plan had to provide——

Chairman STARK. How much is it? I never heard that mentioned.

Mr. VLADECK. It is a separately established premium, subject to alliance review, that we suspect would be substantially more than the plan would cost if you are under 65.

Chairman STARK. But I still have to pay, if I go into Medicare, I have to pay my part B——

Mr. VLADECK. That is right.

Chairman STARK [continuing]. Plus probably at least $100 for a supplemental policy to pick up the co-pays and deductibles. I don't think you have made that clear.

Mr. VLADECK. Apparently not.

Chairman STARK. In all 239 pages, why didn't you suggest that? Certainly I have gotten this question and answer book from the White House PR group. Are you just avoiding that?

Mr. VLADECK. No. I am quite certain it is in the plan, and we just haven't done an adequate job of responding to your questions today. It is very clear that there is a separate premium structure for the over-65s, as there has to be because they are so much more expensive.

Chairman STARK. So what you are really saying then is, by holding it to $1,800, then you are—in other words, Medicare now is costing us $4,000 an individual?

Mr. VLADECK. Yes.

Chairman STARK. I think my previous idea of going to $2,000 across the board and—you talk about a notch, and for adding a couple hundred dollars a year to the major part of the population, the 240 million who aren't in Medicare, we could let the seniors just bop right along, couldn't we, without sticking it to them?

Mr. VLADECK. The only additional comment I would make on that——

Chairman STARK. It would get us a lot of votes.

Mr. VLADECK. The additional comment I would make on that is, whatever it might do to the under-65 premium now, if you think about the changes in the age structure of the population we anticipate 20 years out, it might have a much more significant effect.

Chairman STARK. Claude Pepper said that gets into the area of buying green bananas. At this stage of the way this legislation is taking place, I wouldn't buy any green bananas for a celebration of the victory.

Nancy, your turn.

Mrs. JOHNSON. Thank you. I would just like to share with you some figures from a Department of Commerce table that was published recently, Trends In Public and Private Sector Health Care Spending. According to this, private sector health care spending increased 10.2 percent in 1989; public sector health care spending increased 14.2 percent in 1989.

The next year it was 4.8 percent in the private sector, 18.9 percent in the public sector. In 1991 it was 4.1 percent in the private sector and 15.6 percent. So we are talking triple; that in the public sector, costs have risen at triple the rate as in the private sector in 1991, 1992 and close to that in 1993.

The projections for 1993 are a little better—6 percent in the private sector, almost 14 percent in the public sector.

Given that kind of performance record on cost control, two questions: How comfortable are you that government under the new plan is going to be able to control costs in the private sector more effectively than the private sector has; and specifically, how do you anticipate, what new strategies will you adopt to cut Medicare costs, the rise in Medicare costs in half over 3 years?

You remember ProPAC, you know that the recommendations you made to increase Medicare reimbursement rates we did not accept, and so you know that the gap between Medicare reimbursement rates and real costs has continued to grow in recent years. You therefore are aware that we primarily controlled cost growth in the public sector, as badly as we did it, through price fixing. ProPAC never came to us and said, reorganize the delivery system.

We had Medicare Select. You didn't come to us and say make it nationwide. So you have worked with this system along with us for many years.

What new strategies will you recommend to make sure that 1½ years from now, or maybe 2 years from now, over 1 year Medicare growth rates will be reduced by 4 percent, and over 3 years, by 50 percent?

Mr. VLADECK. Let me respond to that in several pieces if I can.

First of all, those Department of Commerce numbers are total expenditures and overlook the fact that the private sector was covering significantly fewer people while the public sector was covering a lot more people. The totals at present shifts in outlays largely as a result of the fact that, due to the recession, millions of people lost private health insurance coverage and many of them became eligible for Medicaid, which had very substantial increases in eligibility.

The largest share of the public sector cost increases in the period you describe on the Medicaid side, and the biggest contributor to Medicaid cost increases was the increased number of people enrolled in Medicaid because of the recession and because of the eligibility expansions. On a per capita basis, the Medicare cost increase experience and the Medicaid cost increase experience, with one exception over the last decade, compare favorably on a per-person basis to the experience in the private sector.

The one exception to that is the extraordinary growth in Medicaid disproportionate share payments, which have more to do with intergovernmental financial transfers than they do with the health system and which should be rendered largely moot by the changes in the structure of health care financing under the new system.

Having said that, I want to emphasize that we are not prescribing a mechanism of cost containment for the private sector. We are establishing targets that the private sector will need to meet in terms of cost containment that will encourage the private sector to build on what it has learned and contain costs however it thinks best, provided it does so within a framework of rules that doesn't permit it to drop people from coverage, to reduce people's coverage, or to shift risk on others.

We are not prescribing to the private sector how to control costs.

Mrs. JOHNSON. Certainly, as one who introduced the first bill reforming the insurance industry to make all the changes you now support, I understand very well how important they are to the people of America and what power they have to address some of the problems that our people face. But to say that you are not establishing costs in the private sector, especially when you served on ProPAC and you know exactly how the current global budget or target in the Medicare law works and how it has very specifically affected price after price in Medicare is, in my estimation, misleading.

We have concrete experience with exactly the kind of mechanism that you are proposing in this bill; that is, set premiums and backed up by global budget. We have that in Medicare. And the rational impact of the target which was set below the cost of care was to reduce reimbursement rates below what ProPAC said should be the reimbursement rates. So what global budgets do is take what ProPAC says we should do for hospitals, what the Physician Payment Review Commission says we should do for physicians, and then say, X times Y has to equal D, and if it doesn't, we are going to have X minus 10 times Y minus 25 so that it will equal D. That is what that backstop says.

So if you cannot tell me how you are going to reach the targets in the plan and give me some idea of what new strategies you are going to employ to do a far more aggressive job of controlling Medicare costs in the future than we have in the past, then that tells me that that global budget will snap in. It won't be a backstop; it will be a plan driver.

It is important that you be able to enumerate and give us some idea today of what strategies you are going to employ that are different than the strategies that we have employed in the past, because if you can't be specific, then the people out there will be hurt.

We have had experience in Medicare and in the VA system. VA people in my district have to go to New York City from central Connecticut to get a hearing test. Why? Because it is a globally funded budget, below the cost of care for our veterans. So we have accommodated.

Are your strategies to control volume in Medicare going to result in Medicare recipients in Connecticut having only one hospital where they can get certain procedures, because for older folks from the icy hills of my district to get to Hartford, as the one hospital that might be able to prepare something, will be dangerous and is going to cut access and is going to cut quality.

So I want to hear strategies that are going to be different in the future than in the past in Medicare so that the premiums won't go up, the quality will stay the same, but you will reach your target of cutting the rising cost of Medicare in half; and you owe us those strategies and that is my question.

Chairman STARK. Do you want to yield to me for a answer? You try first.

Mr. VLADECK. Let me say that I interpret the experience under the Medicare prospective payment system very differently. In 1983, ProPAC set the initial rates under the prospective payment system that, in retrospect, turned out to be about 115 percent of costs in that year. Since 1983, prospective payment rates have grown in the aggregate at a rate significantly higher than input price inflation in hospitals. What has happened, however, has been that in the absence of economic discipline on the private sector side, hospitals have not felt they were operating under financial constraints, have been able to shift costs, and are now spending, per case, substantially more than Medicare is paying.

I would argue that is not because Medicare pays too little. I would argue it is because given unlimited abilities to increase their revenue, hospital costs have risen faster than otherwise would have been necessary.

Further, I would tell you that ProPAC has a couple of times explicitly addressed the issue, and we explicitly addressed the issue this year in reconciliation in talking about Medicare savings; that from an economic point of view one could reduce Medicare payment levels further were it not for the problem of the differential between Medicare payment rates and private sector payment rates, which do create a problem of access for Medicare beneficiaries, at least potentially.

The problem is not that Medicare is paying too little. The problem is that the private sector is prepared to pay much more.

As long as the private sector is prepared to pay much more than Medicare, we will never be able to control Medicare outlays. So that in a system in which there is financial constraint on the private sector, it becomes possible to impose comparable constraint on the Medicare program without having a negative effect on access.

Chairman STARK. I will recognize Mr. McDermott.

Let me break, if you will, for 5 or 8 minutes to give everybody a stretch break.

Mr. MCDERMOTT. As a physician, I was going to suggest that Mr. Vladeck might be willing to take 3 minutes——

Chairman STARK. We will reconvene and stay no later than 2 o'clock.

Mrs. JOHNSON. May I respond?

Chairman STARK. After the break. I have had a request for a break, and I apologize because we haven't given the witnesses a break.

[Recess.]

Chairman STARK. We will resume. Dr. McDermott will inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I want to say that I think that it is very important, to say to those people who are listening or watching this hearing, to understand the complexity of this system. This kind of process must go on. There is no way this can move quickly because it is too complicated. We appreciate your willingness to sit here and answer questions.

Let me ask you another question which I think needs to be resolved. We give food stamps in this country to people who are at 185 percent of poverty. We recognize that for a family of four, $28,000 or whatever the figure is, 185 percent, $25,000, that that is not sufficient to feed your family and cover the other needs in this country.

this is a program that is a mandatory purchase. I presume, although this is called a premium and people might think, well, I will have to sit down at the end of the month and fill out a check and send it off, it will be a payroll deduction, be taken right out of the check. It will look like a tax, like FICA. They won't have any choice about it; it will be gone.

You chose the number at which to begin subsidizing at 150 percent of poverty. My belief is, from looking at that is that you simply are going to create other social problems or you are not going to get universal access in putting that kind of tax on people down at the bottom.

I keep wondering what Murphy's law will come into effect here, because if you do that, if you put that kind of tax on people at that level, they are not going to be able to pay their other bills some way or other. We recognize that in food. I would like to understand why the number 150 percent of poverty was picked, and I would like to know if that is negotiable. Did somebody decide that that was the right amount? How did you get to that figure?

Mr. VLADECK. I don't know that there is any great science in the 150 percent or 160 percent, but I can tell you the philosophy that underlies it, although again, I suspect that there is no magic, exact, correct number.

But I think the President believes very strongly—and I think it is consistent with our policies in a number of regards—in two symmetrical things. One is that everybody who works full-time should have a reasonable income and basic security relative to health care and the other essentials of life; but similarly, that everybody who works full-time at an income level within the range of most working people should be able to contribute something for their own health care rather than having that paid for entirely from the public sector.

Whether the precise correct number for that is 150 or 160 or 200 percent of the poverty level, I don't think is a matter of some scientific formula predicting that. I would suggest, however, that we

are talking about 20 percent of premium cost which, by definition, will be an average premium cost and presumably some plans will be at lower prices and therefore involve a lower dollar contribution on the part of the employee family. So, we are not talking about an extraordinarily large amount of money, I would expect.

When you have this kind of partial government subsidy/partial individual payment, you have problems of where to draw the line and whether to draw a vertical or sloping line. There is no answer, just a judgment call, determined in part by values and part by costs and availability of funds.

That is what we thought was a reasonable or defensible level, but I think one could argue either more or less.

Mr. MCDERMOTT. Do you anticipate that the subsidy proposal will subsidize fully up to 150 percent of poverty, or is it a graduated scale that you have worked out. How are you anticipating that subsidy working for those people—think about the people at 150.

Are they going to get the whole cost of their 20 percent paid or are they going to get a sliding fee scale?

Ms. FEDER. We have been operating on a sliding scale and the specifics of that we have been exploring.

As you know, we have been working on not only that but alternative mechanisms that I believe you have proposed. So it is not meant to be the same number throughout the scale, and we are looking at a reasonable protection and a reasonable phasing of that protection.

Mr. MCDERMOTT. But nobody has actually decided what that is yet?

Ms. FEDER. We are looking at it as we speak, and we will have it for you in the legislative proposal. We have had these discussions several times over the last several months, and we have heard your concerns and are trying to respond to some of them.

Mr. MCDERMOTT. I agree with the President and I believe, as opposed to many other people in this discussion, that he is concerned and committed to having universal coverage. I don't for 1 minute question his desire to make that a reality.

There are some people who want to talk about it, but in fact they have put together a system where it will never occur. This voluntary stuff is just nonsense. The question is whether he will actually get it by the kind of mechanism he has set up.

I think that is the nub of what we have to work together toward. If we don't get universal access, we will never get cost containment.

Ms. FEDER. I think that we agree 100 percent. I also think that there are two separate issues. One is the degree of protection or obligation we are talking about, and is what happens if it is not collected.

We are setting up a system where the coverage is guaranteed and the alliances are responsible for dealing with collections and with bad debt. So I think both aspects have to be examined.

Mr. MCDERMOTT. When I set up the Washington basic health plan in the State of Washington, I made sure that it went to 200 percent of poverty, and there was a sliding fee scale. That is another part of my question, How do you administer that? It gets more complicated the more whistles and bells you put on it, which

is why I was trying to figure out whether you were going to have one subsidy or some graduated thing based on what people have.

Let me ask one other question before I stop. What costs do you anticipate for the alliances? I have heard the figure of 200 alliances across the country. What do you figure the total cost is in the process and who pays for it?

Mr. VLADECK. The number we have been working from has been a ball park estimate of about 2.5 percent of the premium volume in the alliance that would be the cost of maintaining the alliance and its operations. I guess you have to multiply that by the number I couldn't supply you earlier, but which we will get to you, which was the total premium volume in the system, then divide by 200 or whatever you expect to be the number of alliances, and that would give you a typical alliance budget.

Mr. MCDERMOTT. So you think that the administrative costs of the alliance will be 2.5 percent?

Mr. VLADECK. That is the number we have been using.

Mr. MCDERMOTT. Do you see any other administration? Is Medicare is on top of that?

Mr. VLADECK. The cost of the plan administration—each plan has an administrative overhead which is separate and in addition to that of the alliance.

Mr. MCDERMOTT. Right now, insurance companies are spending an average of 14 percent on administration, so you are talking 2.5 percent on top of the 14.5 that Prudential is already spending to administer their program?

Mr. VLADECK. We expect the 14.5 percent will come down considerably because of changes in marketing, and standardization of much of the paperwork. We have been using a target number of 8 or 10 percent for plan administrative expense in the overall estimate.

Mr. MCDERMOTT. So we are talking somewhere between 10.5 and 12 percent at the bottom line when it is all over?

Ms. FEDER. I would amend to say that when the chairman talked yesterday about our overall estimates, in order to be conservative, we are using, I believe, a 13.5 percent total.

Mr. VLADECK. If I say 12.5 and you say 13, I don't believe I am misleading the congressman too badly.

Mr. MCDERMOTT. It is close enough for government work.

Mr. VLADECK. I wouldn't use that phrase.

Mr. MCDERMOTT. Thank you very much.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Following on with my colleague's earlier comment, if the private plan is going to have an 8 or a 10 percent administrative cost, you have at least five things that you clearly define as costs that must be folded into the premiums. They are, 2.5 percent of premium for alliance operating costs; 2 percent of premium for contingency solvency guarantee funds—now, that is over and above the contingency funds that every insurer sets aside; we are up to 4 percent now—premiums and assessments that HHS can put on everybody in order to establish a national risk pool if they decide they want to do that; an additional levy on premiums to fund the quality management program of the National Health

Board; and an additional assessment, a surcharge on premiums to fund residency training.

So there are five specific things that you say you are going to shift onto the premium cost, and then there are five other things that you say you are going to fund, but you are not as specific as saying they go into the premium base. One is nonpayment of premiums, which will happen sometimes; reimbursement of essential community providers for 100 percent of cost based on Medicare payment principles and other things.

Now, you may want to get this from general tax revenues, I am not sure. But at least the first five things go into the premium base, so the premiums will cover a lot of things that premiums don't currently, traditionally cover. However, they will be limited by the national global budget and they will not be able to exceed that budget when multiplied by the number of people having premiums and the premium value. So if by chance the administrative costs are higher than you think, and instead of being 2 percent for alliances they end up being 5 percent, just to make it a little more dramatic, then that money doesn't come out of the global budget. It comes out of care. That worries me. I am just going to make that as a statement because we don't have much time.

I have some specific questions that I want you to answer, but I think this issue of premiums backed by a global budget is far more serious; and especially when you look at the new load you are putting into the premium base, that is not the load that is currently there that is solely associated with care and administration of care benefits.

As to things that are completely within your power and directly within your purview of responsibility, Mr. Vladeck, do you plan any efforts to reduce costs in the health care system by reviewing CLIA, the AIDS OSHA regulations, the nursing home regulations, and a number of other Federal sets of regulations that we know out there in the real world impose a number of costs without commensurate benefits? Are you planning an analysis of Federal law and regulation and its impact on health care costs?

Mr. VLADECK. In general, for Federal regulations and under the President's recent Executive Order, even had we not been planning to do it, we are obligated to do a number of cost benefit analyses.

Specifically, we are in the process of reviewing CLIA regulations and are going to be undertaking some amendments to them in the very near future, as well as recommending some legislative changes in CLIA.

I cannot speak to the OSHA regulations. I will claim jurisdictional ignorance on that issue.

On the OBRA 1987 nursing home regulations, I think we are now in a position to demonstrate very significant improvements in the quality of nursing home care directly as a result of those regulations. We do still have some of those regulations either in the proposed rule or interim final form and are actively reviewing them at the moment, but I would be very reluctant to contemplate any considerable reduction in the OBRA 1987 nursing home regulations.

Mrs. JOHNSON. I regret to hear that, because my nursing homes give me exact examples of things that they have to do that are un-

reasonable to do considering the demands on our dollars. But that is a discussion for another time, and I am glad to hear you are looking at the CLIA regulations.

I hope you will talk to Secretary Reich about the OSHA regulations.

Do you also plan to ask Congress to extend the Medicare select program and do you plan to ask us to make it nationwide?

Mr. VLADECK. The Chairman has not asked me to yield on that subject. We have been in discussions with staff of the subcommittee about extension of Medicare select.

Mrs. JOHNSON. Do you plan to recommend improvements in Medicare-Select so that it will more closely mirror the reorganization of the delivery system that you recommend across the board of the private sector?

Mr. VLADECK. The proposal calls for a number of changes in the relationship between Medicare, the Medigap market, and managed care plans that are consistent with greater parallelism between the choices available to Medicare beneficiaries and some of the choices now available in the private sector. The proposed changes in the regulation of Medigap should encourage closed or partially closed panel kinds of arrangements and open-enrollment, level-playing-field kind of choices. That is a very important part of the proposal.

Mrs. JOHNSON. I am sorry to hear words like "encouraged," because in the private sector you are going to do far more than encourage, especially when you look at the details of the premium-setting mechanism. So I think there has to be parallelism between the organization and the delivery system for the seniors and for everyone else.

Will your efforts to reorganize the delivery of care under Medicare specifically address the extraordinary rise in last months of life care costs?

Mr. VLADECK. Let me say two things about all that. One is, we have recently been chastised by our Inspector General for inadequate energy in implementing the law on advanced directives. Hospital compliance with advanced directives is a condition of participation. We are going to redouble our efforts in that regard.

However, I should tell you that in my own view—this is a personal view because I don't think we have a position—I believe that the issue of heroic measures for terminally ill patients is an issue of the utmost ethical and social importance, but not one which poses any significant potential savings for the Medicare program or any other insurer.

The fact of the matter is that 27 percent of Medicare expenditures involve patients in their last years of life, a proportion that has not changed significantly in the last 20 years, despite all the technological changes over that period of time.

But we cannot predict at the start of the last year of life which patients are going to expire during the year and which are going to benefit and have their life expectancy extended from large expenditures, and therefore there is nothing we can really do from an economic point view to save money by intervening.

Mrs. JOHNSON. Thank you. I appreciate both the ethical sensitivity of the issue and its medical complexity. I would appreciate the data that you referred to. I look forward to working with you.

Thank you, Mr. Chairman.

Chairman STARK. Thank you, Mrs. Johnson.

Now that you brought up risk adjustment, let's talk about that a little further. I needn't repeat that the Academy of Actuaries in a sense does not think it can be done. CBO has indicated that they are critical about the success of a premium-cap approach.

There are some problems in the bill pushing for risk adjustment on young people when we have a hell of a lot more data on older people.

Would it not make more sense to start in the data where we have the data, which is on the seniors rather than the young people?

Mr. VLADECK. We are doing both. In fact, a lot of our proposals for Medicare, as you know, hinge on better risk adjustments for Medicare, and we are doing a lot of work on that front as well.

Chairman STARK. Without a working and sophisticated risk-adjustment tool, account cost containment work?

Mr. VLADECK. I think the answer is yes, although it is a little bit more difficult. The reason you need the risk adjustment in a system of cost containment is to ensure that plans aren't saving money by unloading risky patients onto other plans.

Chairman STARK. Let's talk about that. I will stipulate that that is fair game. The experience we have with, say, Prudential, who has testified before committees of Congress that they plan to redline, they will not go into areas where they have to have Medicaid beneficiaries coming to certain providers' offices, such as in the State of Maryland where they are allowed to do it. They said they won't bid in the District of Columbia.

Won't these plans, without risk adjustment, have a strong incentive to avoid high-cost populations? Whether they will be able to or not is a question, but it would seem to me the economic incentive would be gigantic.

Mr. VLADECK. I believe the economic incentive is there, and in the absence of highly sophisticated risk adjusters, it would be necessary for the alliances under State supervision, which in turn will be under Federal supervision, to engage in the more complex but still feasible process of monitoring who is enrolling in what plans, to whom the plans are marketed, and to what extent redlining behavior is occurring.

Chairman STARK. I am glad you brought up that word. We have no redlining legislation or rules that exist in the country today relative to medical insurance or hospitals at all, do we?

Mr. VLADECK. No we don't.

Chairman STARK. So the only experience we have in the United States is redlining regulations in banking and in insurance. Do you have any idea how well that works after—I think I was a banker starting in 1960 when I wrote to then Senator Proxmire about redlining. That gives us 30 years. Do you think that we are able to control redlining in insurance and in banking today? Do you know? I know, but I——

Mr. VLADECK. At the risk of anticipatorily disagreeing with you, Mr. Chairman, let me say that I expect our capacity to enforce anti-redlining laws and that of administrations that believe in civil

rights will be substantially greater than the performance has been over the last decade.

Chairman STARK. If we can identify those people who have been excluded, once we start including them, that means we award this higher financial risk to a variety of plans, and without a way to know how much financial risk we are awarding them, we can't figure out how to pay them.

Mr. VLADECK. Well, I think it is more accurate to say that we will be rewarding or punishing somebody less precisely than we would like if we had perfect risk adjustment. One can envision all sorts of sanctions one could use against plans that engage in unacceptable behavior.

Chairman STARK. In your personal, professional opinion, you think that without risk adjustment, at a higher level, as the state of the art exists in this country or any other country today, that you would be comfortable that we could contain the costs and stop adverse risk selection?

Mr. VLADECK. No, I am comfortable that if we receive the resources we are requesting from OMB for our expanded research and demonstration activity in risk selection, by the time we get to full implementation of the plan we will be far enough along to use interim measures that will prevent the worst problems, and within a few years thereafter, be able to have a technology——

Chairman STARK. You think by the end of the decade, then?

Mr. VLADECK. By the end of the decade.

Chairman STARK. At what cost? How much do you want?

Mr. VLADECK. We are talking about tens of millions of dollars, which is beneath rounding error relative to the rest of the plan.

Chairman STARK. And if at the end of that time we still haven't figured it out?

Mr. VLADECK. Then I think we have to again look at these more cumbersome mechanisms of actually——

Chairman STARK. No, no, no. We have the same—that isn't true. We have the system now in Medicare, it works quite fine without risk adjustment. All we have to do, right, is extend the Medicare system to all, and we don't need risk adjusters, right?

Mr. VLADECK. That would obviate the problem.

Chairman STARK. We have the resources to do that in 9 months, I think you testified?

Mr. VLADECK. We could, yes.

Chairman STARK. I am glad there is a way out.

Mr. MCDERMOTT. Mr. Chairman, if you will yield to me to pursue this for a second, your anticipation is that the bill that will be presented to the Congress will have written into it provisions which prevent redlining?

Mr. VLADECK. That is correct.

Mr. MCDERMOTT. That there will be no possibility within a health alliance for an accredited health plan to exclude any zip code, for instance?

Mr. VLADECK. There will always be the possibility. There will always be people who try to discriminate or cheat, and the question is what mechanisms you have for monitoring that behavior, what sanctions do you have against it, and how you can enforce it.

Chairman STARK. Let me pick up on that. Yesterday Judy testified it is your intention to allow plans, not alliances, plans within an alliance to select geographical areas within an SMSA, and effectively make it easier to red line. Do you think that is a good idea?

Mr. VLADECK. I think there are two different pieces to this. One is, can a plan choose the areas in which it operates. And the second is, can it choose them in such a way that is discriminatory.

Chairman STARK. We call that gerrymandering, and you know we can do that. We have been trying to write reapportionment laws for a hundred years.

The question is, you could avoid that, could you not, by making every plan in every alliance operate in the same area? Could you not?

Mr. VLADECK. That would avoid that problem.

Chairman STARK. There are compromises all through this bill. We could make it work.

Mr. MCDERMOTT. Do you anticipate that language, though?

Ms. FEDER. I wanted to pursue that. In the course of the last several months we have looked at several ways to approach this issue, and I expect we will continue to look at different approaches, but one of the problems we thought with requiring every plan to serve all areas was that it did make it difficult for the development of organized delivery systems that might appropriately limit their scope.

Chairman STARK. How about another option? Eliminate any advertising except through the alliance. Don't let the competing plans run any television, direct mail, radio, newspaper or magazine ads. Only allow the information to be disseminated in an identical form through the alliance.

Ms. FEDER. That is not something that we contemplate in the legislative proposal, but I think that your concern about encouraging selection, and whether or not objective information can overcome that, is a valid concern.

Mr. VLADECK. There is another set of mechanisms that one might contemplate, Mr. Chairman, relative to these issues, and that is to look at the patterns of enrollment in plans by income and by race and by other characteristics about which one is concerned, against established norms or standards, and with established penalties for——

Chairman STARK. This is another whole day's hearing, but the problem is you leave these guys out of the box because you let them back off on capacity. So they get where they want to get, and suddenly when you would say, Now you have to move into this ward, we ain't got no capacity and no interest in getting the capacity.

And what we find in the District of Columbia is no one would have any capacity to go into wards 7 and 8. Just strangely, that would happen. The plan as it is now drafted does no require a plan to open its enrollment if it says it is full to capacity.

Ms. FEDER. Again, I think there are many issues there that we will continue to work on. But one of the—and we talked yesterday about a State or the District of Columbia being able to require plans to go into certain areas. One of the provisions in our pro-

posal, I think, that addresses some of those issues is the requirement to reimburse or contract with essential providers.

And so there is a mechanism for getting capacity in some of those areas.

Chairman STARK. And build a two-tier system?

Ms. FEDER. I think that there are always probably going to be some differences in the system. The question is whether we can build the quality in those systems and the connections between them and other providers that enables them to guarantee first-tier care.

Chairman STARK. The gentleman has the time.

The plan includes $100 billion and change in specific Medicare reductions, and the additional Medicare savings in employer and individual mandates.

There are two questions here. Will working agent Medicare beneficiaries continue to have the choice of Medicare as their primary health plan, as they do under current law, and then, what additional level of Medicare savings are assumed as a result of the employer mandate?

Mr. VLADECK. In reverse order, sir, I don't remember the exact number. There will be a specific number on that on the choice issue. The answer is, we expect, yes, we are still trying to figure out all the mechanics of that, and that is not entirely done, but our expectation is that will be, yes.

Chairman STARK. Most of these are informational and not adversarial, by the way. What does the plan assume about the ESRD population? Does the standard benefit package include dialysis and transplant services?

Mr. VLADECK. Yes, it does.

Mr. MCDERMOTT. With no limitations whatsoever?

Ms. FEDER. Consistent with the current arrangements where after a period of time Medicare is the payer for getting dialysis.

Mr. MCDERMOTT. So anybody who can find a heart can get a heart transplant?

Chairman STARK. I was referring to kidney transplants.

Mr. MCDERMOTT. OK.

Chairman STARK. The increase in part B premium, to fund 25 percent of the prescription drug cost, was there an estimate—it may have changed now, but can you give me a barnyard——

Mr. VLADECK. The last number I saw, which I read in the newspaper, but apparently it is consistent with the estimates, is in the range of $11 to $12 a month.

Chairman STARK. Why don't you have a formulary in the plan?

Mr. VLADECK. I think it is fair to say we have been trying in the definition of the drug benefit to walk a line in terms of both good public policy and our expectations, frankly, about political practicalities. We are reasonably confident that if we can do the kind of job we think we can do both on rebates and other price issues and on utilization review, that many of the benefits that we would have otherwise received from a formulary ought to be available to us.

Chairman STARK. On the unlikely assumption that the PMA would have any social conscience developed late in life, and let us

get a formulary passed, you have no objection to it as a procedural matter?

Mr. VLADECK. Our proposal does not now include a formulary for a Medicare drug benefit.

Mr. MCDERMOTT. In designing your plan, did you make any assumptions about additional costs either for the AIDS epidemic or the developing tuberculosis epidemic, given the fact that the costs are sort of rolling down the line quietly, about to hit us some point down there? Did you make any assumptions whatsoever about that, either of those?

Mr. VLADECK. No, nor did we, I must say, make any assumptions based on some of the epidemiological phenomena that would seem to argue in the other direction. So there isn't, as far as I know in the economic model, an epidemiological basis——

Mr. MCDERMOTT. You didn't go up or down?

Mr. VLADECK. As far as I know, as I say, there is no epidemiological adjustment. Again, there are things in terms of reduced mortality from hypertension-related disease and so forth that saves money, and we haven't built that into it either.

Mr. MCDERMOTT. You didn't try to figure out what can you save by preventive care either?

Mr. VLADECK. We added in only the cost of preventive care, not any saving.

Ms. FEDER. You asked earlier in the day about choosing HMOs versus fee-for-service plans and other areas where we expect there could be savings, but those are not scorable savings, and we have only focused on scorable savings in the estimates.

Mr. MCDERMOTT. Your testimony yesterday was that you are trying to change the system, both the financing system and the delivery system. And you are trying to change the delivery system for a specific reason. Obviously you believe—it is a matter of belief—that somehow you will get some savings out of driving people in a certain direction by financial incentives.

Ms. FEDER. You are quite right. Essentially what is scorable is the premium cap. That is what we are focusing on, and that is the way in which we believe we will guarantee the savings.

Chairman STARK. Do you believe they will be scored?

Ms. FEDER. What we are focusing on is seeking a scorable mechanism.

Let me finish that point. It is our belief that other factors, then the cap, will produce those savings. But those are not accepted as scorable.

Chairman STARK. What is your second best? Let's say they don't get scored.

Ms. FEDER. I think we are going to have it in the place that it will be scorable.

Chairman STARK. And how much? How will the income-related premium be administered? Through the Tax Code or some other mechanism?

Mr. VLADECK. I would anticipate it would be through the Tax Code.

Ms. FEDER. Essentially—excuse me, you are—I defer entirely. I apologize.

Mr. VLADECK. That is a Medicare issue.

Ms. FEDER. I am back to my cage. Sorry.

Chairman STARK. Through the Tax Code?

Mr. VLADECK. That is right.

Chairman STARK. Is the income threshold still in the $100,000 per individual range?

Mr. VLADECK. I believe the proposal from which we are working, which began with the proposal in the President's budget, has been modified to reduce the notching effect and create a slope rather than a notch.

Chairman STARK. That is music to my ears.

Mr. VLADECK. That is still being refined.

Chairman STARK. The plan spells out in great detail what are covered services, but it does not include the coverage of surgery or radiation done in your favorite place, freestanding non-hospital centers.

Was that intentional or was that just an oversight in the drafting?

Mr. VLADECK. In general I believe, Mr. Chairman, that the plan defines covered services but not sites of service. The presumption is that the plans would make the determination as to whether from a qualitative and economic point of view, what site would be preferable to provide the service.

Chairman STARK. But when you have to come to setting the fee-for-service plan, then it would make a substantial difference, wouldn't it, as our experience in Medicare shows?

Mr. VLADECK. That is correct, and I honestly can't answer that relative to fee for service.

Chairman STARK. Just as a side-bar, is that an issue you are prepared to deal with this year just as an interim savings?

Mr. VLADECK. It depends on the extent to which we do any interim amendments.

Chairman STARK. To the extent you want to do that, we should do that sooner than later.

Mr. VLADECK. I understand.

Chairman STARK. Back to the whackos who are writing these public relations, discrediting you good, hard working, well educated health care experts, the briefing book. The briefing book I received earlier this week from the White House says that I am supposed to answer this question this way, and basically it says I should tell the doctors that they are going to make the decisions about health care in the future, not insurance company bureaucrats.

Now, this plan does put the burden of limiting health costs entirely on the health insurance companies by capping their premiums. Is that not correct?

And wouldn't it seem reasonable that the insurance companies would respond by doing even more than they already are doing to pressure doctors to hold back services and to do utilization review, and doesn't that make that statement confusing?

Mr. VLADECK. If you look at the experience, Mr. Chairman, I would argue that the more effective, the better, older group practice model HMOs, and in fact the better multi-specialty group practices, have contained their savings to a considerable extent by doctor-driven decisions.

Chairman STARK. But not fee for service.

Mr. VLADECK. I agree with you there as well.

Chairman STARK. And as the majority of all the new development in managed care.

Mr. VLADECK. The entire presumption of this plan is that people are going to vote with their feet over time, and that people will be happier in plans where the doctors are making those decisions than where insurance company bureaucrats are making those decisions.

Ms. FEDER. As will practitioners.

Mr. VLADECK. As will practitioners, and there will be measurable differentials in quality. To the extent that is the case——

Chairman STARK. Let's be realistic for a minute here. The big five, the GHAA guys, are fighting like hell to knock out the power of the alliances so they can continue to negotiate, and you know very well that Aetna and Prudential and these guys have done nothing but hassle doctors and hospitals to get their savings. And they want to survive, and under your plan they would be the only ones to survive if you knock all the small insurance companies out of business, as Mr. Gradison rightly says.

As a practical matter, the doctors will be right back in the soup, except whoever instead of dealing with Blue Cross, they will be dealing with those kind folks in Prudential and Aetna.

Mr. VLADECK. We believe in many markets the plans that will be most successful will, in fact, be organized and managed by local provider groups. We believe there will be specific elements of the proposed bill that help establish incentives to move——

Chairman STARK. But you have no empirical evidence of that?

Mr. VLADECK. We have no empirical evidence for a lot of this stuff.

Ms. FEDER. It is new.

Chairman STARK. It is like cold fusion. It will give us all something free. Nobody will have to pay anything. There will be no environmental danger. It will be free energy for the rest of our life. No empirical evidence that it will work.

Ms. FEDER. Mr. Stark, I think we would all agree we are taking on a new endeavor, but that we have experience, as Bruce was just indicating, that it has worked in places.

Chairman STARK. Where? You know, that is a question we never did finish with yesterday. Where has anything worked that you are talking about?

Ms. FEDER. I actually was just building on the comment that Bruce just made with respect to long-standing staff model HMOs and with respect to multi-specialty practices, and that we have——

Chairman STARK. That was leading to my last question. Those are growing, and the indication is, whether we pass any legislation or not, by the end of this decade there will be more managed care and group practices regardless of what we legislate. Don't you agree with that?

Ms. FEDER. I think that may well be true, but——

Chairman STARK. Now, what happens, just for instance, let's say if this plan is going to have guidelines for the alliances, correct? There have got to be some. We have said it. You have to make sure there is no redlining, we have to make sure there is quality.

Let me postulate this. The plan could work, then, with only one alliance, couldn't it, with the Federal alliance? It would not have

to have 50 State alliances for the plan to succeed. Is that not correct, technically?

Ms. FEDER. The plan has many opponents.

Mr. VLADECK. The answer is that if you have one Federal alliance, you have a plan that would be successful in some places and unsuccessful in others.

Chairman STARK. Isn't that likely to be the case if you have 50 alliances in 50 different States? Look at the experience on certificate of fees in California and New York. New York was very successful, California was a bleeding failure.

I am suggesting there is nothing crucial to this plan about alliances. It works without them, interestingly enough.

Mr. VLADECK. I think it is very hard to figure out how to make the restructuring in the insurance market, which is really very central to this plan, work without alliances or something very much like them.

Chairman STARK. Simple. The same way we do in Medigap. You will never get it through the States. We have had State insurance regulation since the beginning of time, since the beginning of this century. It doesn't work. We have Equitable under indictment in a couple of States, we have insurance companies going broke. State regulation of insurance companies has been a failure.

It is working so far in our Medigap. It is going to take a while. There is absolutely no reason, and John Dingell will love to hear this because he will get jurisdiction, that insurance companies—you set a minimum set of Federal standards, and it is working.

So to rebut your presumption, we will get insurance regulation a whole hell of a lot faster here than you will ever get it out of 50 States. There is no reason on God's green earth that insurance regulation has to vary from State to State in terms of integrity of the assets, sales procedures, or minimum risk. There is no case that can be made that insurance regulation should be State specific.

So I don't know, again, why you couldn't operate this without the alliances.

Ms. FEDER. I think there are two issues here. One is we do include Federal standards for insurance. So we agree that there need to be Federal standards. I think the alliances serve another purpose, which is essentially to centralize the marketing, as we talked about earlier. The alliance is a centralized marketing location at which individuals, not companies, are choosing their health plans. And when we look at the small groups——

Chairman STARK. If that is the only thing, then you two guys have to pass my test. We have two of the country's leading experts. Bruce can maybe do this. Maybe you both can.

Ms. FEDER. I am going to sit back then and let Bruce do it.

Chairman STARK. How much do you pay, if you don't mind, each pay out of your paycheck for your FEHB plan, Judy?

Ms. FEDER. I am covered by my husband's plan.

Chairman STARK. How much comes out of his paycheck?

Ms. FEDER. I should be able to pass this test because you have given it to me before.

Chairman STARK. Then you should know.

Ms. FEDER. That is true.

Mr. VLADECK. I don't remember.

Chairman STARK. I am going to go down the line now and talk about benefits under your plans. I know I won't have to go very far and you are not going to be sure what your benefits are, particularly if I get into mental health, out-of-pocket caps.

What I am suggesting is, for those of us who spend practically our whole careers messing around in this field and who have a plan that has great detail of comparative shopping, the Federal employees, most Federal employees in most health care walks can't answer that and really don't care. Once a year they look at this and figure out, and they change. But beyond that, there is no need. The Federal employee bulletin serves all 50 States perfectly.

And I see no reason why that couldn't work. Now, you may get your alliances, but I will tell you, you would ease a lot of pain politically if we could just say, let's let those alliances go for a while, if a State chose to do it, create the atmosphere in which they could. Give a little money if they want it. But let's us start with a plan that we can guarantee to everybody and then if the States choose to come in, let them. You don't think they can make that decision? You suggest this to Ira and see what he says.

Ms. FEDER. Let me state something that I started to state earlier, which is I think, as I said, different components to this plan. As I stated yesterday, it is the President's philosophy that we ought to build—when we are talking about changes in delivery system, that the States and localities are the place to have the first——

Chairman STARK. I am aware of that. And I am counting on the performance of the new reformed HCFA and Health and Human Services to show the President the error of his assumptions and explain to the President by good deeds that Medicaid, which has been screwed up by the 50 Governors, is not Medicare, which has been run by HCFA. Even under the Republicans it has been run very well. Imagine how well it could be run under a Democratic administration. Once he tells Ira that so he gets the signals out, we can maybe write a bill.

Thank you.

Ms. FEDER. Thank you, Mr. Chairman.

Mr. VLADECK. Thank you.

[Whereupon, at 2 p.m., the hearing was adjourned.]

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